Foot and Ankle Specialists of Virginia, P.C.

Acct # _____

☐ New Patient ☐ Information Change

PATIENT INFORMATION

Name (Last) _____ (First) _____ (M.I.) _____

Address _____ City _____

State _____ Zip _____ (M/F) _____ Social Security No. _____

Date of Birth _____ Age _____ Home Phone # _____ Work Phone # _____ Cell Phone # _____

Referring Physician _____ Primary Care Physician _____

Date last seen by Primary Care Physician _____ In Case of Emergency, Contact: _____ Phone: _____

Employer _____ Employer's Address _____ Marital Status _____

E-mail Address _____ Shoe Size _____

RESPONSIBLE PARTY

Guarantor's Name _____ Specialist Co-pay Amount _____

Address _____

Patient's Relationship to Guarantor _____ Guarantor's Employer _____

Guarantor Phone Numbers: Home# _____ Work# _____ Cell# _____

Guarantor's Social Security No. _____ Guarantor's Date of Birth _____ (M/F) _____

PRIMARY INSURANCE

Name of Insurance Company _____ Subscriber's Name: _____

Patient's Relationship to Subscriber: _____ Subscriber's ID # _____ Group # _____

Insurance Address _____

Insurance Phone # _____ Subscriber's Date of Birth _____ (M/F) _____

SECONDARY INSURANCE

Name of Insurance Company _____ Subscriber's Name: _____

Patient's Relationship to Subscriber: _____ Subscriber's ID # _____ Group # _____

Insurance Address _____

Insurance Phone # _____ Subscriber's Date of Birth _____ (M/F) _____

I, the undersigned, hereby consent to and authorize the administration and performance of all treatments, the administration of any needed anesthetics; the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, the use of prescribed medications; the performance of diagnostic procedures; the taking and utilization of cultures and performance of other medically accepted laboratory tests, all of which the judgement of the attending physician or their assigned designees may consider medically necessary or advisable.

I fully understand that this consent is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

I hereby authorize Foot and Ankle Specialists of Virginia, P.C. to release medical information to any healthcare provider or third-party insurance company for the purpose of treatment, payment or operations, which may pertain to my care. I hereby authorize payment directly to Foot and Ankle Specialists of Virginia, P.C. of benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by any third party carrier and in accordance with the contractual terms and participatory agreements. Further, I acknowledge that I am indebted for past due charges, and I understand that I am financially responsible for those charges also. Should this account become delinquent, I agree to pay a collection fee not to exceed 33 1/3% of the balance then outstanding in addition to any court costs and/or attorney fees.

MEDICARE PATIENTS: I authorize Foot and Ankle Specialists of Virginia, P.C. to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Foot and Ankle Specialists of Virginia, P.C.

In accordance with the provisions of Section 32.1-45.1 of the Code of Virginia (whenever any health care provider or any person employed by or under the direction and control of a health care provider, is directly exposed to body fluids of a patient in a manner which may according to current guidelines of the Centers for Disease Control, transmit human immunodeficiency virus), the patient whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus. If there is an exposure and the patient's test is positive the attending physicians will notify the patient, any person exposed, and the Virginia Health Department and appropriate counseling will be offered. I have reviewed and understand my patient rights and responsibilities. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient's Signature _____ **Date** _____

MEDICATIONS

Name: _____ Dosage: _____ Condition: _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

PAST MEDICAL HISTORY:

_____ Diabetes (high blood sugar)
_____ diet
_____ oral medication
_____ injections
_____ Heart Dx
_____ Anemia
_____ Arthritis
_____ Asthma
_____ Bleeding Tendency
_____ Back Trouble
_____ Cancer
_____ Convulsions
_____ Dizziness
_____ Glaucoma
_____ Gout
_____ Hepatitis
_____ High Blood Pressure
_____ Kidney Disease / Bladder Trouble
_____ Intestinal Disorders
_____ Liver Disease
_____ Low Blood Sugar
_____ Lung or Breathing Disorder
_____ Phlebitis
_____ Poor Circulation
_____ Rheumatic Fever
_____ Stomach Ulcers
_____ Stroke
_____ Sickle Cell Disease / Trait
_____ Varicose Veins
_____ Venereal Dx - AIDS

PAST SURGICAL HISTORY / HOSPITALIZATIONS:

Year: _____ Reason: _____ Complications: _____

_____ _____ _____

_____ _____ _____

ALLERGIES:

Describe Reactions

_____ Novocaine / Xylocaine _____
_____ Penicillin _____
_____ Codeine _____
_____ Aspirin _____
_____ Iodine _____
_____ Sulfa Drugs _____
_____ Adhesive Tape _____
_____ Wool / Cotton _____
_____ Specific Drugs _____
_____ Other _____