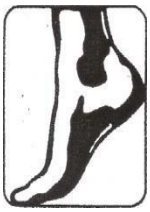


Podiatric Care
of Northern Virginia

Dr. William Knudson
Dr. David Chan

Established 1981 **Surgery Sports General Podiatry**

Patient Forms

Today's Date: _____ / _____ / 20____ **Referred by:** _____ **Shoe Size:** _____

Patient Name: _____ **Date of Birth:** _____ / _____ / _____ **Sex:** M F

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Home Phone #: ( ) _____ **Cell Phone #:** ( ) _____ **May we leave a message?** Y N

Social Security #: _____ **Marital Status:** S M SEP D W **Email Address:** _____ @ _____

Primary Language: _____ **Race:** _____ **Ethnicity:** Not Hispanic / Hispanic

Emergency Contact: _____ **Phone #:** _____ **Relationship:** _____

Primary Care Doctor: _____ **Phone #:** _____ **City/State:** _____

Pharmacy: _____ **Phone #:** _____ **City/State:** _____

Occupation Status: Student Employed Unemployed Retired

Name of Employer: _____ **Job Title:** _____

Work Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Primary Insurance: _____ **ID #:** _____ **Group #:** _____

Subscriber Name: _____ **Date of Birth:** _____ **Relationship to Patient:** _____

Employer: _____

Secondary Insurance: _____ **ID #:** _____ **Group #:** _____

Subscriber Name: _____ **Date of Birth:** _____ **Relationship to Patient:** _____

Employer: _____

ACTIVE MEDICATIONS – Please list any medications you are currently taking including any over the counter and vitamins.

Name of Medication **Dosage** **How often do you take it?**

1._____

2._____

3._____

4._____

ALLERGIES - Do you have any allergies to any medicine, food, metal, material or other? Y N

If yes, please list your allergy below:

Allergic to: _____ Reaction: _____

Allergic to: _____ Reaction: _____

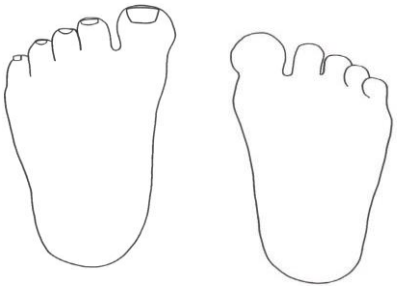
CURRENT PROBLEM – What specific issue(s) would you like us to treat today? _____

Where is the pain/issue located? Please mark below OR write your answer below in the space provided.

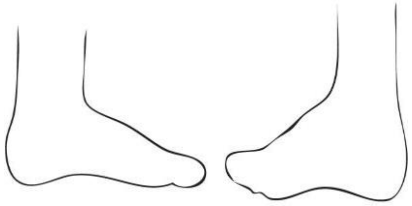
_____

_____

Left Foot

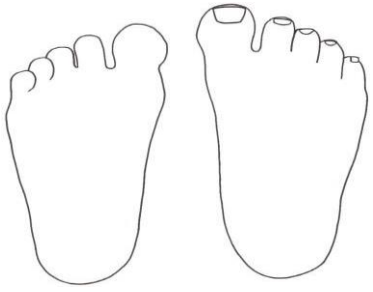


Top of Foot Bottom of Foot

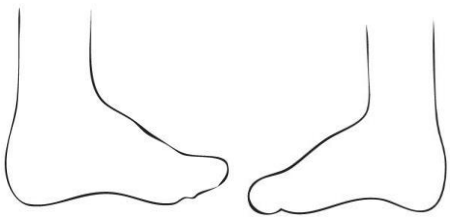


Inside of Foot Outside of Foot

Right Foot



Bottom of Foot Top of Foot



Outside of Foot Inside of Foot

YOUR MEDICAL HISTORY

Are you currently being treated for any medical condition? Y N

If so, what condition(s) are you being treated for? _____

_____

Have you ever had any of the following medical conditions:

Acid Reflux	Y	N	Fibromyalgia	Y	N	Neuropathy	Y	N
Anemia	Y	N	Gout	Y	N	Open Sores	Y	N
Arthritis	Y	N	Heart Attack	Y	N	Pneumonia	Y	N
Asthma	Y	N	Heart Disease/Failure	Y	N	Polio	Y	N
Back Pain	Y	N	Hepatitis	Y	N	Rheumatic Fever	Y	N
Bladder Infections	Y	N	HIV/AIDS	Y	N	Sickle Cell Disease	Y	N
Abnormal Bleeding	Y	N	High Blood Pressure	Y	N	Skin Disorder	Y	N
Blood Clots	Y	N	Kidney Disease	Y	N	Sleep Apnea	Y	N
Blood Transfusion	Y	N	Liver Disease	Y	N	Stomach Ulcers	Y	N
Bronchitis/Emphysema	Y	N	Low Blood Pressure	Y	N	Stroke	Y	N
Cancer	Y	N	Migraine/Headaches	Y	N	Thyroid Disease	Y	N
Diabetes Type 1 or 2	Y	N	Mitral Valve Prolapse	Y	N	Tuberculosis	Y	N
OTHER:								

Do you smoke cigarettes or any tobacco product? Y N If so, how many packs a day? _____ How many years? _____

Do you use any recreational drugs? Y N If so, what type? _____ How many years? _____

Do you drink alcohol/liquor? Y N If so, how often? Rare Socially Moderately Daily

FAMILY MEDICAL HISTORY

Has anyone in your family had/have any of the following medical conditions listed above? If yes, please list:

Condition: _____ Relationship to you: _____ Mother or Father side?
Condition: _____ Relationship to you: _____ Mother or Father side?
Condition: _____ Relationship to you: _____ Mother or Father side?
Condition: _____ Relationship to you: _____ Mother or Father side?
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Condition: _____ Relationship to you: _____ Mother or Father side?
Condition: _____ Relationship to you: _____ Mother or Father side?
Condition: _____ Relationship to you: _____ Mother or Father side?

ACKNOWLEDGMENTS

Insurance/Billing

I understand that payment for professional services rendered is due and payable upon completion of each visit. I further understand that there will be some services that may not be covered by my health insurance and that I will be responsible for those non-covered services along with any copay, co-insurance and deductible due.

I authorize payment of medical benefits including Medicare to Podiatric Care of Northern Virginia. I promise to pay any outstanding balance to Podiatric Care of Northern Virginia in scheduled monthly payments, if needed, as established by the Office Manager.

Late Cancel/No-Show Fee

I understand I will be assessed a $25.00 fee for any appointment in which I cancel/no-show without providing notice within 24 hours.

ACKNOWLEDGMENT OF RECEIPT of NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices by Podiatric Care of Northern Virginia and that I have read or had the opportunity to read it if I so choose and understand the notice.

Release of Information

I hereby authorize Podiatric Care of Northern Virginia to discuss my information whether relating to my care or financial responsibility to the below listed person(s):

Name: _____ Relationship to me: _____ Phone #: _____

Name: _____ Relationship to me: _____ Phone #: _____

I have read and understand all of the above and have completed this form to the best of my knowledge.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Patient Signature

Leesburg Office: 224 D Cornwall Street NW, Suite 102, Leesburg, Virginia 20176
Phone: 703.777.5830 | Fax: 703.777.5155
pcnvonline.com