Welcome to our Practice

ASSOCIATED PODIATRY OF CENTRAL VA
2129 LAKESIDE DRIVE LYNCHBURG VA 24501

PATIENT INFORMATION

Please print clearly

Patient First Name______________________ MI________ Last Name______________________

Male ○ Female ○ Marital Status: Single ○ Married ○ Widowed ○ Separated ○ DM ○

Spouse/Partner Name ______________________ Spouse Date of Birth ______________________

Do you have children? Yes ○ No ○ Ages______________________

Patient Home Street Address______________________ Apt#__________

PO Mailing address [if applicable]______________________

City______________________ State______________________ Zip __________

Patient Home Phone#[ ]______________________ Cell Phone#[ ]______________________

Patient email address [please print clearly] ______________________

Patient Date of Birth______________________ Age__________ Social Security Number __________

Patient Height__________ Weight__________ Shoe Size__________

Patient Occupation______________________ Employer Name______________________

Employer Address______________________ Phone[ ]__________

BEST CONTACT INFORMATION

Home Phone ○ Cell phone ○ Work ○ Email ○

If patient is a minor - provide Name of parents or guardian ______________________

Address of parents or guardian ______________________

Phone #[ ]______________________ Cell phone[ ] ______________________

Emergency Contact Name______________________ Phone__________ Relationship__________

PAYMENT AND INSURANCE INFORMATION

- Please present your insurance card and drivers license upon arrival

Check here no health insurance ○

Full Name of Insured ______________________ Relationship to Patient__________

Insured SS#______________________ Insured Date of Birth __________

Insured Employer ______________________

Employer Address______________________

According to my insurance, I am responsible to pay a Co-Pay Amount $__________ Deductible Amount $__________

Payment today will be made by: Cash ○ Check ○ Visa ○ Master Card ○ American Express ○ Discover ○

My insurance requires a referral from my PCP before I see a specialist. Yes ○ No ○

REFERRAL INFORMATION

We appreciate your referrals! Who may we thank for referring you to our office?

Name______________________ Address______________________

Is this person your: PCP ○ Other Specialist ○ Family Member ○ Friend ○

Other Referral Sources (check all that apply and please specify names where indicated):

Internet Search [name]↓	Phone Book [name]↓	Our Practice Website	Newspaper Ad [name]↓	Saw our sign	Insurance Plan or Website [name]↓	Other [explain]↓

Please turn over to continue

PODIATRIC HISTORY

Have you ever been to a podiatrist before? Yes ○ No ○

What is your **chief foot complaint** for which you came to be treated?

When did it begin? ____________

Did you receive treatment for this condition? Yes ○ No ○

If so, what type?

Circle the **degree of pain** you are currently experiencing:

Minimal 1 2 3 4 5 6 7 8 9 10 **Severe**

Have you ever had any of the following foot conditions? Please check all that apply:

- ☐ Ankle Instability
- ☐ Arthritis
- ☐ Back Pain
- ☐ Blisters
- ☐ Bone Spurs
- ☐ Bunions
- ☐ Burning Feet
- ☐ Corns/Calluses
- ☐ Diabetic Evaluation
- ☐ Flat Feet
- ☐ Fracture
- ☐ Fungal Infections (skin/nail)
- ☐ Gout
- ☐ Hammertoes
- ☐ Heel Pain
- ☐ Hip Pain
- ☐ Infections
- ☐ Ingrown Toenails
- ☐ Intoe - Out toe walking
- ☐ Joint Pain
- ☐ Knee Pain
- ☐ Limb Length Discrepancy
- ☐ Neuromas
- ☐ Numbness or tingling in foot or toes
- ☐ Plantar Fasciitis
- ☐ Postural Fatigue
- ☐ Pronation
- ☐ Shin Splints
- ☐ Sprains
- ☐ Sweating/Odor
- ☐ Tendonitis
- ☐ Tired feet
- ☐ Ulcers
- ☐ Warts

MEDICAL HISTORY

Have you ever been treated for any of the following conditions? Please ✓ all that apply to you. Put an M if on your mother's side. Put an F if on your father's side.

____Acid Reflux	____Hypothyroidism
____Anemia	____Irritable Bowel Syndrome
____Arthritis	____Kidney Problems
____Asthma	____Liver Disease
____Bleeding Disorders	____Low Blood Pressure
____Cancer	____Nervous Disorder
____Depression	____Muscle or Joint Pain
____Diabetes	____Peripheral Arterial Disease
____Epilepsy	____Parkinson's Disease
____Fatigue	____Phlebitis
____Fibromyalgia	____Poor Circulation
____Headaches	____Respiratory Disease
____Heart Condition	____Rheumatic Fever
____Hepatitis	____Shortness of Breath
____High Cholesterol	____Seizure Disorders
____HIV/Aids	____Stomach Ulcers
____Hypertension	____Stroke
____Hyperthyroidism	____Varicose veins

MEDICATIONS

Are you currently on Blood Thinners? Yes ○ No ○

You can provide a printed list of your medications or list them below:

Name of Medication	Strength/Mg	Take how often?

Do you currently use: Cigarettes or Tobacco? Yes ○ No ○ Quit ○

If yes, for how long? ____________How many pks/day?________

If quit, when? ______yrs _______months

Alcohol use? Yes ○ No ○ If yes, quantity _______daily _____weekly

SURGERIES

Please list all surgeries	Approximate Date

Name of MD/Family Physician ____________

Address ____________

Date of Last Visit ____________

ALLERGIES

Have you ever had any adverse side effects or allergies to:	YES	NO		YES	NO
Adhesive Tape			Metal/Jewelry		
Anticoagulants			Novacaine		
Anti-inflammatory Meds			Peanuts		
Aspirin			Penicillin		
Codeine			Seafood		
Cortisone			Other antibiotics		
Iodine			Other pain medication		
Latex			Other		

If other, please explain ____________

SIGNATURE ON FILE AND PERMISSION TO TREAT

- I understand that the information provided on this form is true and correct to the best of my knowledge.
- I request that payments of authorized benefits be made on my behalf for any services furnished by Associated Podiatry
- I authorize any holder of information about me to release any information needed to determine these benefits or the benefits payable to related services to the insurance agent.
- I recognize my financial obligation of any coinsurance, co-pays or deductibles and non-covered services that may be required.
- I hereby give permission to Associated Podiatry and any qualified staff to evaluate, diagnose and treat my foot and/or ankle condition as may be deemed necessary.

Patient or Authorized Signature ____________

If not patient, state relationship ____________ Date ________