ADVANCED PACE FOOT & ANKLE CENTER

2616 Sherwood Hall Lane # 401 Alexandria, VA 22306 **6355 Walker Lane #305 Alexandria, VA 22310**

Name: _____ Birthdate:_____/_____/_____

Address:_____City:_____
State: _____ Zip: _____ Marital Status: Single Married Divorced Widowed

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Name of Parent: (If patient is a minor) _____Birthdate: _____/_____/_____

Patient's Employer: _____ Occupation:_____

Name of Spouse (If insured) _____ Birthdate: _____/_____/_____

Name of nearest relative not living with you: _____ Phone: _____

Family Physician: _____ Office Number: _____

I consent to a written summary of this examination to be sent to my family physician YES NO

Pharmacy: _____ Phone: _____

How did you learn about us? _____

Insurance Company: _____

Relationship to Patient: Self Spouse Parent Other

ID #: _____ Group #: _____

Secondary Insurance : _____

ID #: _____ Group #: _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I agree to pay all fees immediately upon completion of all services UNLESS other arrangements are made in ADVANCE. If applicable co pays are not paid at the time of visit, a $10.00 processing fee will be applied to my account. My account will be considered delinquent if the balance due has remained unpaid for a period greater than 60 days. In the event of my delinquency, I agree to pay all cost of collection, including attorney's fees (1/3 of the uncollected balance) and interest on any unpaid balance from the date the balance was due, at a rate of 1.5 % per month (18% per year). I permit a copy of this release to be used instead of the original.

Signature: _____ Date: _____

(Patient or Responsible Party)

Medical Questionnaire

Please complete ALL sections. The information you provide is important to us to provide the best possible care for your problem and will remain confidential.

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?
Circle all that apply:

AIDS/ARC	Convulsions/Epilepsy	Hepatitis	Rheumatic Fever
Anemia or Abnormal Bleeding	Diabetes	High Blood Pressure	Sickle Cell Trait
Angina or Chest Pain	Glaucoma	HIV	Stomach Disease
Arthritis	Gout	Kidney Disease	Stroke (CVA or TIA)
Asthma/Lung Disease	Heart Attack (MI)	Low Back Pain	Thyroid Disease
Blood Clots	Heart Disease	Lupus	Tuberculosis
Cancer	Heart Murmur	Mitral Valve Prolapse	Ulcers
Circulatory Disease		Phlebitis	Venereal Disease

Do you smoke? YES NO How much?: _____
Do you drink alcohol: YES NO How much?: _____

What is your current foot problem? (Please describe) _____

_____

_____

PREVIOUS SURGERIES YES NO (Please list and date all surgeries) _____

_____

Any complications from anesthesia or surgery? YES NO Explain: _____

_____

FAMILY HISTORY (Circle and indicate if it's your mother or father)
Arthritis Cancer Diabetes Heart Disease High Blood Pressure Kidney Disease Overweight

Please list ALL medications that you currently use _____

_____

_____

Do you take or have you ever taken any addicting drugs? YES NO **Are you pregnant?** YES NO

HAVE YOU EVER HAD AN ALLERGIC REACTION OR SIDE EFFECT FROM ANY OF THE FOLLOWING?
Adhesive Tape Aspirin Iodine Novocaine Penicillin Sulfa Other: _____

HEIGHT _____ WEIGHT _____ SHOE SIZE(WIDTH) _____

I hereby authorize Advanced Pace Foot & Ankle Center to apply for benefits on my behalf for covered services and request payment are made directly to Advanced Pace Foot & Ankle Center (accept assignment) from my insurance company. I certify that the information I have reported with regard to my insurance coverage to be correct and further authorize the release of any necessary information, including medical information, to my insurance company in order to determine insurance benefits to which I may be entitled. I permit a copy of this to be used instead of the original.

Signature of policy holder: _____ Date: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICE AND CONFIDENTIAL COMMUNICATION PREFERENCE

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the Notice.

_____ _____

Patient Name (Please print) Date

_____

Signature of patient or authorized representative (If applicable)

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of Patient: _____

(Please print)

Date of Birth: _____

I request that all communication to me (by telephone, mail or otherwise) by Advanced Pace Foot & Ankle Center and/or its staff be handled in the following manner:

For written communication: _____

_____

For oral communication: _____

If the address provided above is not your home address or is not a street address, please provide us with a street address for purposes of ensuring payment:

_____

_____

_____ _____

Patient Signature or Authorized Representative Date