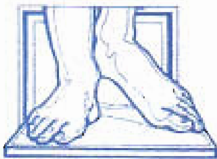

ASSOCIATED FOOT & ANKLE CENTERS OF NORTHERN VIRGINIA, P.C.

DOUGLAS E. STABILE, D.P.M. • RICHARD DERNER, D.P.M. • ANDY J. ROUSSEL, D.P.M. • MARK L. SCRIPPS, D.P.M.

LAKE RIDGE FOOT & ANKLE CENTER
1721 Financial Loop • Lake Ridge, VA 22192
(703) 491-9500 • FAX (703) 491-9994

STAFFORD FOOT & ANKLE CENTER
945 Garrisonville Road
Stafford, VA 22556
(540) 720-0700 • FAX (540) 720-4449

WE ARE VERY PLEASED TO WELCOME YOU TO OUR OFFICE. PLEASE ANSWER THESE QUESTIONS TO HELP US BECOME ACQUAINTED. IF YOU NEED HELP, PLEASE ASK

PATIENT'S NAME: First Middle Last | SPOUSE'S NAME

HOME ADDRESS Street City State & Zip | HOME PHONE

EMPLOYED BY | ADDRESS | WORK PHONE EXT. #

SPOUSE/PARENT EMPLOYED | ADDRESS | PHONE | BIRTHDATE | SEX

PATIENT SOCIAL SECURITY NO. | PATIENT OCCUPATION | HEIGHT | WEIGHT | AGE

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE? | MARITAL STATUS ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow

IN CASE OF EMERGENCY, CONTACT | RELATIONSHIP | PHONE

FINANCIALLY RESPONSIBLE PERSON ☐ PATIENT ☐ SPOUSE ☐ PARENT ☐ OTHER | NAME AND ADDRESS IF DIFFERENT FROM PATIENT | HOME PHONE | WORK PHONE

SUBSCRIBER INFORMATION: NAME & ADDRESS OF SUBSCRIBER IF DIFFERENT FROM PATIENT

DATE OF BIRTH | RELATIONSHIP TO PATIENT | SUBSCRIBER'S SOCIAL SECURITY NO. | HOME PHONE | WORK PHONE

PRIMARY INSURANCE CO.

Ins. Co. Name:
Address:
I.D. No.:
Group:
Subscriber: (PERSON'S NAME)
HMO Plan I.D. No.:
PPO Plan I.D. No.:
Phone No.:
Effective Date:

MEDICARE

I.D. No.:
Effective Date:

SEND INSURANCE FORM TO:

Who approved treatment:

SECONDARY INSURANCE CO.

Ins. Co. Name:
Address:
I.D. No.:
Group:
Code:
Subscriber: (PERSON'S NAME)
Effective Date:

WORKMAN'S COMPENSATION

Ins. Co. Name:
Address:
I.D. No.:
Group:
Date of Injury:
Subscriber: (PERSON'S NAME)
Phone No.:
Effective Date:

Patient's Authorization

I, ______________________, hereby authorize Associated Foot & Ankle Centers of Northern Virginia, P.C. to apply for benefits on my behalf for covered services rendered by Associated Foot & Ankle Centers of Northern Virginia, P.C., and request that the payments from my insurance company ______________________ (OTHER INS. CO. NAME) be made directly to Associated Foot & Ankle Centers of Northern Virginia, P.C..(or in case of Medicare Part B benefits, to myself or to the party who accepts assignment). I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above named billing agent, Blue Cross/Blue Shield of National Capital Area/Blue Shield of Virginia (or in case of Medicare Part B benefits, to the Social Security Administration and Health Care financing Administration) Medicare and/or ______________________ (OTHER INS. CO. NAME). I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above named carrier at any time in writing.

PATIENT ACCOUNT NO.

SIGNATURE OF SUBSCRIBER OR BENEFICIARY | IDENTIFICATION NO. | DATE

PLEASE NOTE:

Services are rendered to you, the patient. Responsibility for payment to this office is with you, the patient, not the insurance company. This form has been specifically designed to assist in the completion of your insurance form. Our office, however, cannot accept the responsibility for collecting your insurance claim or negotiating reimbursement schedules.

Please turn to the back of this page and answer all questions. This information is important to your health and records.

CHIEF CONCERN/PRESENT ILLNESS:

What is your present foot/ankle problem? ______________________________

____

How long have you been bothered by the above? ______________________________

What have done for your foot/ankle problem? ______________________________

____

PAST MEDICAL HISTORY:

Family doctor's name: ______________________________

Doctor's Address: ______________________________ Phone: ______________

Are you now or have you been under a physician's care during the past two years? ☐ Yes ☐ No

Date of last complete physical exam: ______________________________

Are you presently taking any medicine? ☐ Yes ☐ No If yes, what? ______________________________

____

____

Check if you presently have or were treated for:

☐ High blood pressure	☐ Diabetes	☐ Heart Disease	☐ Stomach problems
☐ Epilepsy	☐ Liver trouble	☐ Cancer	☐ Seizures
☐ Gout	☐ Anemia	☐ Glaucoma	☐ Phlebitis
☐ Arthritis	☐ Bleeding tendency	☐ Ulcers	☐ Sickle Cell Disease/Trait
☐ Kidney disease	☐ Asthma	☐ Nervous condition	
☐ Broken bones	☐ TB	☐ Allergies	
		☐ Other: ______________	

Medications allergic to: ☐ Aspirin ☐ Codeine ☐ Novocaine ☐ Xylocaine ☐ Iodine ☐ Adhesive Tape

☐ Penicillin Other: ______________________________

Do you smoke? ☐ Yes ☐ No

Have you had surgery? ☐ Yes ☐ No TYPE ______________________________ Year ________

TYPE ______________________________ Year ________

(WOMEN) ARE YOU PREGNANT? ☐ Yes ☐ No If yes, when are expecting? ______________

FAMILY HISTORY

Circle if any blood relatives have had

Arthritis Cancer Diabetes Heart Disease High Blood Pressure Kidney Disease Overweight

Foot problems similar to yours ______________________________

Is there any other general or foot health information that should be known? ______________________________

I HEREBY GIVE PERMISSION TO DR.STABILE/DR. DERNER/DR. SCRIPPS/DR. ROUSSELL TO EXAMINE, DIAGNOSE AND TREAT MY FEET MEDICALLY, OR SURGICALLY AND ATTEST THAT THE ABOVE INFORMATION IS ACCURATE AND TRUE.

PATIENT (PARENT/GUARDIAN) SIGNATURE ______________________________ DATE ______________

THANK YOU FOR YOUR COOPERATION