

Northern Virginia Foot & Ankle Associates LLC

DATE: _____

8221 Old Courthouse Road, Suite 102, Vienna, Va 22182 Phone: (703) 734-1311 Fax: (703) 734-9090

FRANK J. SMITH, D.P.M. FACFAS MICHAEL A. KLEIN, D.P.M. FACFAS MUKESH D. BHAKTA D.P.M.

Last Name	First Name	M.I.	Street Address		Apt. #
City	State	Zip Code	Home Phone ()		
SSN #	DOB	Age	Marital Status: M S Widow Sep. Div.		
Employer's Name & Address			City	State	Zip Code Work Phone ()
Financially responsible person, if different from patient Home Phone () Work Phone ()			Email Address		
Spouse's Name	Person, other than spouse, to contact in case of emergency		Relationship	Contact's Phone ()	
How did you hear about our practice? (circle)					
Yellow Pages Sign	Other Patient Drive-By	Dr.'s Referral Website	Ins. Co Other:	TV Commercial	Friend
Referring Physician's Name	Your Primary Physician's Name		Physician's Phone ()		

INSURANCE COVERAGE

Primary Ins. Co	Name of Policy Holder	Relationship	Policy Holder's DOB	Policy ID #	Group #
Secondary Ins. Co.	Name of Policy Holder	Relationship	Policy Holder's DOB	Policy ID #	Group #
Policy Holders Employer				Employer's Phone #	

MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Northern Virginia Foot & Ankle Associates LLC for any services furnished to me by the physician. I authorize any folder of medical information about me to be released to the Health Care Financing Administration and any agent information needed to determine these benefits or benefits payable for related services.

Date _____ Signature _____

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I, the undersigned, authorize payment of medical benefits to Northern Virginia Foot & Ankle Associates LLC for any services furnished to me by the physician. I understand I am financially responsible for any amount not covered by the contract. I also authorize you to release to my insurance company information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claim benefits. I permit a copy of this authorization to be used in place of the original.

Date _____ Signature of Subscriber or Beneficiary _____

MEDICAL HISTORY

Reason for visit: Date when symptoms began and description of symptoms

If problem is accident related, indicate date accident occurred and place of injury

Have you been treated by another physician for this problem? If yes, list physicians name and treatment

Past Medical History (check all that apply)

AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Heart Valves or Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sinus Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eye Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Varicose Veins	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Weight Loss, Unexplained	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Other Past Medical History _____

Have you had any surgery? If yes, please list all past surgeries:

_____ Date: _____
_____ Date: _____
_____ Date: _____

Are you currently taking any medications? If yes, list name & dosage:

1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

Do you have any medication allergies? If yes, list and describe reaction:

Do you (circle): Drink Alcohol Smoke Tobacco? If yes, how much? _____

Do you experience abnormal bleeding with surgery, cuts, extractions, or trauma? YES NO

Are you, or is there any chance you may be pregnant? YES NO

Put a check by any conditions below that any blood relatives have or had:

___ DIABETES ___ FOOT PROBLEMS (similar to yours) ___ HEART DISEASE ___ STROKE ___ GOUT
___ ARTHRITIS ___ HIGH BLOOD PRESSURE ___ KIDNEY DISEASE ___ TB ___ CANCER

Other _____

Please write your: Shoe Size _____ Weight _____ Height _____