



Debra J. Aleck, DPM, FACFAS  
And Associates

[www.podiatryltd.com](http://www.podiatryltd.com)

*Medical, Biomechanical and Surgical Care of the Foot and Ankle*

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3511 Western Branch Blvd.  
Portsmouth, VA. 23707  
Phone: 757-397-FOOT (3668)

Appt..Date \_\_\_\_\_

Appt. Time \_\_\_\_\_

**WELCOME TO OUR PRACTICE!**

PLEASE COMPLETE ALL OF THE ATTACHED PAPERS AND BRING THEM WITH YOU AT THE TIME OF YOUR APPOINTMENT. ALSO, PLEASE REMEMBER TO BRING THE FOLLOWING:

- **YOUR INSURANCE CARDS**

The insurance company requires that we have a copy of ALL your insurance cards on file. If we are to bill your insurance company(s), these will be required. Please provide all cards that apply to you as the patient. We will copy these for your medical record.

- **A PICTURE I.D.**

- **CO-PAY**

Many insurance companies require that a set amount be collected by our office at *each* visit. You may obtain this information from your insurance card, or by calling your insurance company.

- **INSURANCE REFERRAL Insurance referrals are the patient's responsibility!**

Some insurance companies require that the member go through their Primary Care Physician (PCP) in order to be seen by a specialist. This information may be on your insurance card, or can be obtained by calling your insurance company.

**IF A REFERRAL IS NEEDED:** Please pick your referral up from your PCP's office and bring it with you on the day of your appointment. If your PCP's office has informed you that they will fax the referral, or that they have entered it into their referral system, you must call at least one day prior to your appointment with us to be sure that we have received it. **UNFORTUNATLY, IF WE DO NOT HAVE YOUR REFERRAL AT THE TIME OF YOUR APPOINTMENT, YOU WILL NEED TO BE RESCHEDULED!**

- **PRIOR TREATMENT INFORMATION**

If you have seen a doctor for this problem before, it will prove helpful for you to bring any X-rays, test results (such as MRI, vascular studies, or CT scans) and chart notes from previous treatment.

***THANK YOU FOR CHOOSING PODIATRY, LTD. FOR ALL YOUR FOOT AND ANKLE CARE. WE LOOK FORWARD TO HELPING YOU WITH ALL YOUR PODIATRIC NEEDS.***

**DIRECTIONS:** OUR OFFICE IS IN MIDTOWN SECTION OF PORTSMOUTH (NOT CHURCHLAND)

**From 264:** Take the Fredrick Blvd Exit. Continue RIGHT, past Wal-Mart, to High Street (Rt. 17) and turn LEFT. We are in the second block, on your LEFT, next to AAA.

**From Points West:** Follow Rt. 17 into Portsmouth as though you are heading towards Maryview Medical Center. After you cross the Churchland Bridge (becomes High St. W) turn right at the second light. You will then be on Western Branch Blvd. Follow this road through the light at Rodman Ave. We are located just past the AAA building on the Right.



### PATIENT INFORMATION

This information is confidential and is important for our files and your health.

PATIENT \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ M / F  
FIRST MI LAST

WHAT WOULD YOU LIKE TO BE CALLED? \_\_\_\_\_

MARITAL STATUS  Single  Partnered  Married  Separated  Divorced  Widowed

HOME ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE (H) \_\_\_\_\_ (W) \_\_\_\_\_

CELL \_\_\_\_\_ EMAIL \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_

PATIENT EMPLOYER \_\_\_\_\_

EMPLOYER'S ADDRESS \_\_\_\_\_

OCCUPATION \_\_\_\_\_

NAME OF SPOUSE/GUARDIAN \_\_\_\_\_

SPOUSE/GUARDIAN EMPLOYER \_\_\_\_\_

SPOUSE/ GUARDIAN BUSINESS TELEPHONE \_\_\_\_\_

DO YOU HAVE MEDICAL INSURANCE?  YES  NO

ARE YOU THE  INSURED  DEPENDENT

PRIMARY INSURANCE NAME \_\_\_\_\_

SUBSCRIBER NAME AND NUMBER \_\_\_\_\_

SECONDARY INSURANCE NAME \_\_\_\_\_

SUBSCRIBER NAME AND NUMBER \_\_\_\_\_

NAME, ADDRESS, AND PHONE NUMBER OF PERSON TO CONTACT FOR AN EMERGENCY:

\_\_\_\_\_  
SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

HOW DID YOU HEAR ABOUT OUR PRACTICE?

NAME \_\_\_\_\_

ADDRESS & PHONE \_\_\_\_\_

# MEDICAL HISTORY

PATIENT'S NAME \_\_\_\_\_ CHART NO. \_\_\_\_\_

WHAT BRINGS YOU TO OUR OFFICE TODAY? \_\_\_\_\_

ARE YOU IN GOOD HEALTH?  Yes  No      WEIGHT \_\_\_\_\_ HEIGHT \_\_\_\_\_

<b>Primary Care Physician:</b>		<b>Date last seen:</b>	
<b>How often do you go?</b>		<b>Reason</b>	
<b>Are you Pregnant? If yes, how many months?</b> _____		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Are you Diabetic?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No    Year Diagnosed _____		Do you take insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Surgeries</b>			
Year	Reason	Hospital /Medical Center	
<b>Other hospitalizations</b>			
Year	Reason	Hospital / Medical Center	
<b>Allergies to medications</b>			
Name the Drug		Reaction You Had	
<input type="checkbox"/> Penicillin		<input type="checkbox"/> Other antibiotics _____	
<input type="checkbox"/> Sulfa		<input type="checkbox"/> Novocaine	
<input type="checkbox"/> Tape		<input type="checkbox"/> Iodine	
<input type="checkbox"/> Penicillin		<input type="checkbox"/> Aspirin	
<input type="checkbox"/> Sulfa		<input type="checkbox"/> Codeine	
<input type="checkbox"/> Tape		<input type="checkbox"/> Codeine	
<b>Have you seen a Podiatrist Before?</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Former Podiatrist Name</b>		When?	
Reason			
<b>Have you had Physical Therapy before?</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Where</b>		When?	
Reason			

# MEDICAL HISTORY

PATIENT'S NAME \_\_\_\_\_ CHART NO. \_\_\_\_\_

Please check all conditions that you currently have or have had.

<input type="checkbox"/> Asthma	<input type="checkbox"/> Stroke	<input type="checkbox"/> Gall Bladder Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Blood clots	<input type="checkbox"/> Liver problems
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Bleeding problems	<input type="checkbox"/> Lung problems (TB, Pneumonia)
<input type="checkbox"/> Heart trouble	<input type="checkbox"/> Bleeding tendency	<input type="checkbox"/> Kidney Disease (Stones)
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Circulation problems	<input type="checkbox"/> Stomach trouble
<input type="checkbox"/> Heart valve replacement	<input type="checkbox"/> Hardening of arteries	<input type="checkbox"/> Trouble with vision
<input type="checkbox"/> Joint replacement	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Rheumatic fever/Scarlett fever	<input type="checkbox"/> Anemia	<input type="checkbox"/> Bursitis
<input type="checkbox"/> Gout	<input type="checkbox"/> Allergies/Hayfever	<input type="checkbox"/> Joint pain or stiffness
<input type="checkbox"/> Cramps in feet/legs	<input type="checkbox"/> Skin condition	<input type="checkbox"/> Low back pain
<input type="checkbox"/> Numbness in feet/legs	<input type="checkbox"/> Headaches	<input type="checkbox"/> Recent weight loss
<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Scarring tendency
<input type="checkbox"/> Swelling feet/ankles/legs	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Psychiatric problems

Pain in other areas \_\_\_\_\_

OTHER ILLNESS or PROBLEMS \_\_\_\_\_

<b>Have you been exposed to HIV/AIDS?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Have you been exposed to Hepatitis?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Have you ever had a blood transfusion? When?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

## HEALTH HABITS AND PERSONAL SAFETY

<b>Exercise</b>	<input type="checkbox"/> Sedentary (No exercise) <input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf) <input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) <input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
<b>Diet</b>	Are you dieting?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	# of meals you eat in an average day?			
<b>Caffeine</b>	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola
	# of cups/cans per day?			
<b>Alcohol</b>	Do you drink alcohol/beer/wine?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?			
	How many drinks per week?			
<b>Tobacco</b>	Do you use tobacco?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - /day	<input type="checkbox"/> Pipe - /day	<input type="checkbox"/> Cigars - /day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit		
<b>Drugs</b>	Do you currently use recreational or street drugs?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?			<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Do you need Prophylactic Antibiotics prior to seeing a dentist or having surgery?</b>				<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Why?</b>	What do you take?			
<b>Personal Safety</b>	Do you live alone?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have frequent falls?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have vision or hearing loss?			<input type="checkbox"/> Yes <input type="checkbox"/> No

# MEDICAL HISTORY

PATIENT'S NAME \_\_\_\_\_ CHART NO. \_\_\_\_\_

<b>FAMILY HEALTH HISTORY</b>					
		AGE	SIGNIFICANT HEALTH PROBLEMS		
		AGE	SIGNIFICANT HEALTH PROBLEMS	AGE	SIGNIFICANT HEALTH PROBLEMS
<b>Father</b>				<b>Children</b>	<input type="checkbox"/> M
					<input type="checkbox"/> F
<b>Mother</b>					<input type="checkbox"/> M
<b>Sibling</b>	<input type="checkbox"/> M			<input type="checkbox"/> F	
	<input type="checkbox"/> F			<input type="checkbox"/> M	
	<input type="checkbox"/> M			<input type="checkbox"/> F	
	<input type="checkbox"/> F			<input type="checkbox"/> M	
	<input type="checkbox"/> M			<input type="checkbox"/> F	
	<input type="checkbox"/> F			<input type="checkbox"/> M	
	<input type="checkbox"/> M			<input type="checkbox"/> F	
	<input type="checkbox"/> F			<input type="checkbox"/> M	
					<b>Grandmother</b> <i>Maternal</i>
					<b>Grandfather</b> <i>Maternal</i>
					<b>Grandmother</b> <i>Paternal</i>
					<b>Grandfather</b> <i>Paternal</i>

## PERSONAL HISTORY

**(Please List Hobbies, relatives, work, athletics, what you do for fun, etc.)**



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## NOTICE OF DEEMED CONSENT FOR HIV BLOOD TESTING

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A law was enacted in Virginia in 1989 which authorizes health care providers to test their patients for HIV antibodies when the health care provider is exposed to the bodily fluids of a patient in a manner which may transmit human immunodeficiency virus (HIV – AIDS Virus). In the event of such an exposure, patients will be deemed to have consented to such testing and to have consented to the release of the test results to the health care provider who may have been exposed. Patients will be offered the opportunity for face-to-face disclosure of the results of the HIV test, and counseling.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_

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**AUTHORIZATION AND FINANCIAL INFORMATION**

At Podiatry Ltd., we believe that all patients deserve the very best medical care that we can provide. Everyone benefits when definitive financial arrangements are agreed upon. Our professional services are rendered to you, not the insurance company. Therefore, payment for these services is **YOUR RESPONSIBILITY**.

PLEASE READ AND SIGN THE FOLLOWING.

1. I authorize this office to release any information necessary to expedite claims.
2. I authorize this office to bill my insurance company for medical services with payment made directly to the physician.
3. In the event I receive payment from my insurance carrier, I agree to endorse payment I receive over to the physician.
4. I understand and agree to pay the physician's charge for any missed or cancelled appointment when 24 hour notice is not given. The charges are:

\$ 45.00	"No Show" for missed regular appointment.
\$ 100.00	Missed shoe fitting appointment
\$ 100.00	Missed History and Physical appointment.
\$ 100.00	Missed biomechanical exam and casting for footwear.
\$ 200.00- \$400.00	Missed surgery appointment.

I understand and agree that I am directly and fully responsible to Podiatry Ltd. for payment of all charges. I understand that such payment is not contingent on any settlement, judgment, or insurance payment by which I eventually recover said fee. I realize that if my insurance company fails to pay my balance in full or payment is not made within 60 DAYS, it is my responsibility to pay the physician's bill.

If patient/guarantor defaults as to any terms of this agreement and this account is referred to a collection agency, then the patient and/or guarantor promise and agree to pay all associated costs including collection fees of 33 1/3% of the principal amount owing. I do further agree to pay interest on the unpaid balance from the date that said monies become due and payable.

There will be a \$25.00 charge on all checks returned for insufficient funds.

A photocopy of this authorization shall be considered as effective and valid as the original.

NAME OF PATIENT \_\_\_\_\_

RESPONSIBLE PARTY:

_____	SELF/PARENT/GUARDIAN
Print Name	Relationship to Patient, Circle One

SIGNATURE \_\_\_\_\_ PHONE \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_ DATE \_\_\_\_\_

WITNESS \_\_\_\_\_ DATE \_\_\_\_\_

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