



**Debra J. Aleck, DPM, FACFAS
And Associates**

www.podiatryltd.com

Medical, Biomechanical and Surgical Care of the Foot and Ankle

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 _____

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

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

HEALTH HABITS AND PERSONAL SAFETY

Exercise	<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)			
Diet	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?			
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola
	# of cups/cans per day?			
Alcohol	Do you drink alcohol/beer/wine?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?			
	How many drinks per week?			
Tobacco	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		
Drugs	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
Do you need Prophylactic Antibiotics prior to seeing a dentist or having surgery?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Why?	What do you take?			
Personal Safety	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. _____

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

PERSONAL HISTORY

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



Debra J. Aleck, DPM, FACFAS*

And Associates

www.podiatryltd.com

Medical, Biomechanical and Surgical Care of the Foot and Ankle

NOTICE OF DEEMED CONSENT FOR HIV BLOOD TESTING

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: ___/___/___

3511 Western Branch Blvd., Portsmouth, VA. 23707

Phone: 757-397-FOOT (3668)

*Diplomat of the American Board of Podiatric Surgery

*Fellow of the American College of Foot and Ankle Surgeons



Debra J. Aleck, DPM, FACFAS*

And Associates

www.podiatryltd.com

Medical, Biomechanical and Surgical Care of the Foot and Ankle

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 _____

3511 Western Branch Blvd., Portsmouth, VA. 23707

Phone: 757-397-FOOT (3668)

*Diplomat of the American Board of Podiatric Surgery

*Fellow of the American College of Foot and Ankle Surgeons