Os Wight Foot and Ankle Institute
Podiatric Medicine and Surgery

Patient History

Os Wight Foot and Ankle Institute
Dr. Meng Liu
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Phone: (757) 712-3532
Fax: (757) 866-5430

Today's Date: _____

PERSONAL INFORMATION

Name: _____ Date of Birth: _____ Age: _____

Height: _____ Weight: _____ SSN: _____ Marital Status: _____ Spouse's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

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

Email: _____ Preferred Way of Contact: _____

Employer: _____ Your Position: _____

Whom may we thank for referring you to our office: _____

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT (SKIP IF SELF)

Name of responsible party: _____ Relationship to Patient: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ If Tricare, pleasae provide sponsor SSN: _____

INSURANCE INFORMATION

Primary Insurance: _____ Do you need a referral: ☐ Yes ☐ No

Subscriber: _____ Subscriber Date of Birth: _____ Relationship to Patient: _____

Secondary Insurance: _____ Do you need a referral: ☐ Yes ☐ No

Subscriber: _____ Subscriber Date of Birth: _____ Relationship to Patient: _____

PRIMARY CARE PHYSICIAN

Doctor Name: _____ Practice Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Date Last Seen: _____

PHARMACY

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

MEDICAL HISTORY

What is your reason for your visit today? _____

When did the issue start? _____ Have your symptoms improved, worsened, or remained the same? _____

Is the issue work related? ☐ Yes ☐ No If yes, do you currently have a claim open with the insurance company? ☐ Yes ☐ No

If yes, please provide billing information: _____

MEDICAL HISTORY (Check if you have or had any of the following conditions)

☐ Diabetes: ☐ Type I ☐ Type II ☐ Controlled ☐ Uncontrolled HbA1c: _____

☐ Hypertension (High Blood Pressure) ☐ Kidney Disease ☐ Tuberculosis ☐ Asthma ☐ Gout

☐ Hypotension (Low Blood Pressure) ☐ Rheumatic Fever ☐ Arthritis ☐ Epilepsy ☐ Anemia

☐ Bleeding/Clotting Disorders ☐ PVD (Circulation Disease) ☐ Stomach ulcers ☐ Neuropathy

☐ Hypatitis (Liver Disease) ☐ High Cholesterol ☐ Thyroid Disease ☐ Heart Disease

☐ Cancer: _____ ☐ Other(s): _____

Family History (Check if any of your siblings, parents or grandparents have or had any of the following conditions)

☐ Diabetes ☐ Heart Disease ☐ Hypertension ☐ Anemia ☐ Stroke ☐ Cancer

☐ Other(s): _____

SOCIAL HISTORY

Cigarette (how many packs for how long): _____ Alcohol (how much and how frequent): _____

Recreational Drugs: _____ Other(s): _____

PAST SURGICAL HISTORY

_____

MEDICATIONS

_____

_____

ALLERGIES (Please indicate reactions and severity)

☐ No Known Allergy ☐ Medical Tape: _____ ☐ Iodine: _____

☐ Latex: _____ ☐ Local Anesthetic: _____ ☐ IV Dye: _____

☐ Penicillin: _____ ☐ Sulfa: _____ ☐ Aspirin: _____

☐ Other(s): _____

REVIEW OF SYSTEMS

General: ☐ Unexplainable Weight Loss or Gain ☐ Fevers/Chills ☐ Fatigue

Head, Eyes, Ears, Nose and Throat: ☐ Headaches ☐ Head Injury ☐ Neck Pain ☐ Blurred Vision ☐ Difficulty Hearing ☐ Ear Ringing ☐ Vertigo ☐ Sinus Issues ☐ Nasal Stuffiness ☐ Sore Throat

Respiratory: ☐ Cough ☐ Wheezing ☐ Shortness of Breath

Neurological: ☐ Dizziness/Fainting ☐ Numbness/Tingling ☐ Weakness ☐ Tremors ☐ Seizures

Cardiovascular: ☐ Chest Pain/Tightness ☐ Palpitations ☐ Swelling in Legs/Feet ☐ Loss of Leg Hair

Skin: ☐ Rash/Sores ☐ Lumps ☐ Itching ☐ Dryness ☐ Color/Texture Changes ☐ Nai Changes

Gastrointestinal: ☐ Heartburn/Reflux ☐ Nausea/Vomiting ☐ Constipation ☐ Abdominal Pain ☐ Diarrhea ☐ Bloody Stools

Urinary: ☐ Burning ☐ Frequency ☐ Urgency ☐ Incontinence

Musculoskeletal: ☐ Muscle/Joint Pain ☐ Stiffness ☐ Back Pain ☐ Red/Swelling Joints

Psychiatric: ☐ Nervousness ☐ Anxiety ☐ Depression

Acknowledgement of receipt of

Notice of Privacy Practices from OS WIGHT FOOT AND ANKLE INSTITUTE:

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) and understand the notice.

PRINT YOUR NAME: _____

SIGN YOUR NAME: _____

DATE: _____

Parent or authorized guardian: _____
(If applicable)

SIGN YOUR NAME: _____

DATE: _____

ASSIGNMENT, RELEASE OF RECORD ANDS WAIVER OF LIABILITY

Insurance

In an effort to better serve you and as a courtesy, we will gladly file your Insurance claims using the appropriate AMA procedure codes. If you are uncertain
of your coverage, you should familiarize yourself with the provisions of your medical Insurance policy.

- You realize that not all procedures are covered by all Insurance policies and payment for non-covered procedures is the responsibility of the patient
  or their legal guardian and that you will be billed for these services.
- You agree to authorize payment directly to SEVA Foot and Ankle Center, for all insurance benefits otherwise to you for services rendered on your behalf or on behalf of your dependents,
- *You authorize the use of your signature below on all insurance submissions.

Authorization for Release of Confidential Health Care Information

This authorizes Os Wight Foot and Ankle Institute, to request and receive from the Virginia Department of Health Professions any and all records held by the Department relating to Schedule II-V controlled substances dispensed to the patient named above.

I understand that this authorization permits the Department of Health Professions to disclose confidential health records to Os Wight Foot and Ankle Institute. A copy of this authorization shall be included in my records, There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure as permitted by law,

I understand that, if not previously revoked, this consent will expire one year after the date of my signature below unless otherwise specified.

Responsible Party

The responsible party is the adult receiving treatment, or In the case of the patient being a minor, the responsible party will be deemed the parent/or guardian who ***accompanies the patient. or approves the treatment***.

Collections

The last thing we want to do is sending your account to our collection agency, First Point Collection Resources Inc. If you are having difficulty, please contact our office manager as soon as possible, However, if an account is not paid in full or payment arrangements are not met, the account Information and balance will be forwarded to an outside party for collection.

*If your account balance is unpaid, you agree to pay a collection fee of 33.3% to 50% and all attorney's fees (including litigation, if necessary) in addition to the collection of the unpaid balance.

*lf your account has been sent to our collection agency and you require copies of your records, they will be released as soon as you satisfy the balance on your account.

Returned Check Fee

Any returned check will result in a $35.00 charge added to your existing balance and will be automatically forwarded to our collection agency, First Point Collection Resources Inc.

Broken Appointment Fee

We require a 24 hour advance notice for appointment cancellations, If you fail to cancel your appointment within that 24 hour timeframe, you will incur a $35.00 Broken Appointment Fee.