Patient History

SEVA Foot and Ankle Center
Dr Vihang Bajani
3511 Western Branch Blvd, Portsmouth, VA 23707
Phone: 757-397-FOOT/Fax: 757-397-5889

Today's Date: _____

PERSONAL INFORMATION

Name: _____ Birthdate: _____ Age: ____

Patient SSN#: _____ Height: _____ Weight: _____

Marital Status: _____ Spouse's Name: _____

Address: _____ _____ Apt.#: _____

City: _____ State: _____ Zip: _____

(Circle Preferred Phone#) Home Phone: Work Phone: _____ Cell Phone: _____

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

Employer: _____ Your Position: _____

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT (SKIP IF SELF)

Name of responsible party: _____ Relationship to patient: _____

BillingAddress: Phone Number: _____

If Tricare please provide sponsor's SSN#: _____

INSURANCE INFORMATION

Primary insurance: _____ Do you need a referral: YES/NO

Subscriber: Relationship to patient: _____ Subscriber date of birth: _____

Secondary insurance: _____ Do you need a referral: YES/NO

Subscriber: _____ Relationship to patient: _____ Subscriber date of birth: _____

PRIMARY CARE PHYSICIAN

Doctor: _____ Practice name: _____

Phone: Address: _____

Date last seen: _____ _____

Pharmacy

Name: _____ Address: _____

Phone: _____ _____

MEDICAL HISTORY

Reason for your visit today (Describe foot problems and concerns):. _____

_____

_____

When did the problem start? _____ How long have you had your current symptoms? _____

Have your symptoms increased, decreased or remained the same since they began? _____

Is this injury accident or work related? _____ If yes, do you currently have a claim open with the insurance company? _____

If yes, please provide information for our office for billing: _____

_____

_____

Patient Name: _____

MEDICAL HISTORY (CHECK IF YOU HAVE OR HAD ANY OF THE FOLLOWING)

___ Diabetes Type I/ Type II Controlled/ Uncontrolled

___ Hypertension (High blood pressure)	___ Tuberculosis	___ Asthma	___ Kidney Disease
___ Hypotension (Low blood pressure)	___ Rheumatic Fever	___ Anemia	___ Gout
___ PVD (Circulation Disease)	Arthritis	Cancer	___ Epilepsy
___ Bleeding/Clotting Disorders	___ Stomach Ulcers	___ Thyroid	Heart Disease

___ High Cholesterol ___ Cramps or numbness in the feet or legs

___ Hepatitis (Liver Disease) ___ Other(s) _____

FAMILY HISTORY (CHECK IF ANY OF YOUR SIBLINGS, PARENTS OR GRANDPARENTS HAVE OR HAD ANY OF THE FOLLOWING)

___ Diabetes ___ Heart Disease _____Cancer ___ Hypertension _ Anemia

___ Stroke __ Other_____

PAST SURGICAL HISTORY (INCLUDE ANY AND ALL PROCEDURES, SUGERIES AND OPERATIONS}

_____

_____

MEDICATIONS (INCLUDING NON-PRESCRIPT/ON AND HERBAL MEDICATIONS YOU ARE CURRENTLY TAKING)

_____

_____

ALLERGIES (PLEASE LIST ANY KNOWN ALLERGIES AND REACTIONS}

___ No Known Allergies

___ Penicillin:._____ ___LocalAnesthetic:_____

_____Iodine:,_____ _____Sulfa:,_____

_____Aspirin:_____ _____IVDye: _____

_____Latex:_____ ___ MedicalTape:_____

_____Other(s):_____

REVIEW OF SYSTEMS (Please check all items as they relate to your health)

General:	***Respiratory:***	***Cardiovascular:***	***Gastrointestinal:***	***Head:***
_Weight Loss	_Cough	_Chest Pain/Tightness	_Heartburn/Reflux	_Headaches
_Weight Gain	_Wheezing	_Palpitations	_Nausea/Vomiting	_Head Injury
_Fevers/Chills	_Shortness of Breath	_Swelling of legs/feet	_Constipation	_Neck Pain
_Weakness/Fatigue		_Loss of leg hair	_Abdominal Pain	***Musculoskeletal:***
Ear. Nose and Throat:	***Neurological:***	***Skin:***	_Diarrhea	_Arthritis

_Difficulty Hearing	_Dizziness	_Rash/Sores	_Bloody Stools	_Muscle/joint pain
_Ringing in Ears	_Fainting	_Lumps	***Urinary:***	_Stiffness
_Vertigo	Numbness	_Itching	_Burning	Back Pain
_Sinus Trouble	_Tingling	_Dryness	_Frequent	_Redness/Swelling joints
_Nasal Stuffiness	_LossofStrength	_Color Changes	_Increased Urgency	***Psychiatric:***
_SoreThroat	_Tremors	_Nail/Hair Changes	_Incontinence	_Nervousness
	_Seizures			_Anxiety/Depression
				_Difficulty Sleeping

___ ***Please Check Here if You Have None of the Above***

Reviewed By Doctor _____

SOCIAL HISTORY

Smoking (how many/how long):_____

Alcohol (how much):_____

Recreational Drugs:_____

Other(s):_____

RELEASE OF HEALTH INFORMATION:

RECIPIENT: Name of person or class of persons to whom the Practice may disclose my health information:

Name:_____ Relationship to patient:_____

TERM: This authorization will remain in effect:

From the date of this authorization until the_____day of_____

Until the following event occurs:_____

Other: _____

My signature below authorizes the Practice to use or disclose to the recipient my health information for the term of this authorization.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. If my insurance requires authorization or referral I am responsible for obtaining that information for all services rendered.

I have read all of the information on both sides of this sheet and have completed the above completely. I certify this information is true and correct to the best of my knowledge. I will notify you on any changes in my status or when any of the above information changes.

Printed Name: _____

Signature:_____ Date:_____

Relationship to patient:_____

I ACKNOWLEDGE THAT I UNDERSTAND THAT ALL VISITS WILL BE RECORDED FOR MEDICAL NOTE TRANSCRIPTION PURPOSES.

SIGNATURE:_____

Acknowledgement of receipt of

Notice of Privacy Practices from SEVA FOOT AND ANKLE CENTER, P.L.C.:

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) Print your Name: _____

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 SEVA Foot and Ankle Center, to request and receive from the Virginia Department of Health Professions any and all records held by the Department relating to Schedule 11-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 SEVA Foot and Ankle Center. 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 send 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.

*If 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.

Thank you for reviewing our office policies. Please let us know if you have any questions or concerns. Your signature below confirms that you have read and agree to these policies.

* PRINT NAME of Responsible Party _____

* SIGN NAME of Responsible Party _____

* PRINT DATE _____

Witness (Staff Signature Only) _____