7406 Brook Road
Richmond, VA 23227
804-262-7153
804-262-0104 (fax)

The Podiatry Center

5300 Hickory Park Drive
Suite 104
Glen Allen, VA 23059
804-747-3380

Dr. Glen R. Wilensky
Dr. Julie A. Greenwood

Name:_____
FIRST MIDDLE LAST

_____
Parent's/Guardian's/Spouse's Name

Address:_____

Apt/Suite:_____ City:_____

State:_____ Zip:_____

Date of Birth:_____

Social Security Number: _____-_____-_____

Cell Phone:_____

Home Phone:_____

Work Phone:_____

Email Address:_____

Employer:_____

Occupation:_____

Language:_____ Sex: Male/Female

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Fiancé ☐Separated ☐Domestic Partner ☐Minor

Race: ☐American Indian ☐Asian ☐Pacific Islander ☐Black/African American ☐White ☐Other:_____

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino

Emergency Contact

Name:_____
FIRST MIDDLE LAST

Relationship:_____

Phone:_____

Primary Insurance Company

Insurance Company:_____

Policy #:_____

Group #:_____

Policy Holder Information

Name:_____

SSN#: _____-_____-_____ DOB:_____

Employer:_____

Relationship to Patient: ☐Self ☐Parent ☐ Spouse

Secondary Insurance Company

Insurance Company:_____

Policy #:_____

Group #:_____

Policy Holder Information

Name:_____

SSN#:_____ Date of Birth:_____

Employer:_____

Relationship to Patient: ☐Self ☐Parent ☐ Spouse

Primary Care Physician

Name:_____

Phone #:_____

Pharmacy Information

Name:_____

Phone #:_____

Address:_____

How did you hear about us?_____

Authorization to Release Information and Pay Insurance Benefits

I hereby authorize The Podiatry Center, PC to render medical services to myself (or my child). I authorize the release any information regarding medical history, diagnosis and treatment to my insurance company regarding the claim. Also, by my signature and copies thereof, I authorize payment directly to The Podiatry Center, PC of benefits otherwise payable to me. It is understood that services and supplies may not be covered by my insurance and I agree to pay for these services or supplies rendered. I understand that in the event my account is turned over to an attorney or collection agency, I will be responsible for fees in the amount of 33% plus interest of any unpaid balance and court costs involved.

To our Medicare Patients: I request that payment of authorized Medicare benefits be made on behalf of The Podiatry Center, PC for services furnished to me. I authorize any holder of medical information about me to be released to the health care administration (and its agents) any information needed to determine these benefits or the benefits payable for related services.

Signature _____ Date _____

Consent for Treatment

I consent to the use of disclosure of my protected health information by The Podiatry Center, PC's practice for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of The Podiatry Center, PC's practice. I understand that diagnosis or treatment of me by the physicians at The Podiatry Center, PC may be conditioned upon my consent as evidenced by my signature of this document.

I consent to the use of photography that may be part of the procedure for medical purposes.

I understand I have the right to request restrictions as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Podiatry Center, PC's practice is not required to agree to the restrictions that I may request. However, if the Podiatry Center, PC agrees to a restriction that I request, the restriction is binding on The Podiatry Center, PC's practice.

I have the right to revoke this consent in writing at any time, except to the extent of The Podiatry Center, PC's practice has taken action in reliance on this consent.

My protected health information means health information, including my demographic information, collected from me and created or received by my physician, another health care plan/provider, my employer or a health care clearinghouse. This protected information relates to my past, present, or future physical/mental health or condition and indentifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have a right to review the Notice of Privacy Practice prior to signing this document. The Notice of Privacy Practice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills or performance of healthcare operations of this practice.

The Podiatry Center, PC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of these practices by calling the office and requesting a copy be sent in the mail.

Signature _____ Date _____

Disclosure of Information

I DO____DO NOT____ GIVE PERMISSION to Podiatry Center, PC, to leave information on my answering machine and/or with my family members in regard to treatment plans, referrals, test results and/or billing and payment information

Disclosures may be made to family and/or friends related to the patient's health or as needed for payment of health care services rendered. We will only disclose information relevant to current treatment. By signing the statement, you agree that we may disclose information to the person(s) listed below in person or by phone

Name _____ Relationship _____ Phone Number _____

Name _____ Relationship _____ Phone Number _____

Insurance/Referral Policy Please check with your insurance to confirm that The Podiatry Center,PC and their physicians participate with your plan. You will be responsible for any Co-insurance, Co-pays or Deductibles required by your insurance. Fees will be collected at the time of visit. You will be responsible to obtain a referral. Please understand that we will not be able to see you without a proper referral at the time of service. If a referral is not received, you will be responsible for any cost incurred from your visit.

Non-Participating Insurance If your insurance plan is one which we are not participating providers, you will be responsible for payment in full at the time of service.

No Show Policy The Podiatry Center,PC reserves the right to charge $25 for a no show visit that is not cancelled within 24 hours of the appointment time.

Paperwork Policy A $15 fee will be charged for forms such as disability paperwork, work forms and personal insurances that are not part of our regular billing paperwork. Payment is required at the time of completion.

Medical/Podiatric History Questionnaire

Name:_____ Date of Birth:_____
FIRST LAST

Chief Concern

Reason For Today's Visit? _____

How Long Has This Problem Been Present? _____

Does Anything Improve This Problem? _____

Does Anything Worsen This Problem? _____

What Treatments Have You Tried? _____

Have You Seen A Podiatrist or Other Physician For This Problem? _____

Have You Seen A Podiatrist For Any Other Problems? If So, What?_____

Medication List

Please List Prescribed Medications, Over the Counter Medications, Vitamins and Dietary Supplements

Are You On Aspirin, Coumadin, Lovenox, Heparin or Any Other Blood Thinner? ☐Yes ☐ No

Medication Name	Dosage	Frequency	Prescribing Physician

Allergies

List Medication Allergy and Reaction

Medication		Adverse Reaction

List Below Any Food or Other Allergies and Associated Reaction

_____

Sensitivities

Are You Sensitive to Any of the Following?

		Adverse Reaction
Tape	YES / NO	
Iodine	YES / NO	
Detergent	YES / NO	
Latex	YES / NO	
Local Anesthetic	YES / NO	
General Anesthetic	YES / NO	

Social History

		Frequency	For How Long	What Kind
Tobacco	☐Current ☐Former ☐Never	_____(#)/Day _____(#)/Week	_____(#) Years	
Alcohol	YES / NO	_____(#)/Day _____(#)/Week	_____(#) Years	
Caffeine	YES / NO	_____(#)/Day _____(#)/Week	_____(#) Years	
Recreational Drugs	YES / NO	_____(#)/Day _____(#)/Week	_____(#) Years	

Do You Drive? ☐Yes ☐No

Do You Exercise? ☐Yes ☐No If Yes, How Much? _____(#)/Day _____(#)/Week

Do You Have Children ☐Yes ☐No Are You Currently Pregnant? ☐Yes ☐No

General Medical History

Do You Currently Have or Have You Ever Had History of Any of the Following? Check (☑) As Appropriate To Your Health History

Head, Eyes, Ears, Nose and Throat

☐Yes ☐No Asthma
☐Yes ☐No Glaucoma
☐Yes ☐No Hearing Loss
☐Hearing Aid
☐Yes ☐No Migraines/Head Aches
☐Yes ☐No Visual Problems
☐Glasses ☐Contacts ☐Blurred ☐Other

Circulation

☐Yes ☐No Blood Clots
☐Yes ☐No DVT (Leg Clots)
☐Yes ☐No Pulmonary/Lung Clot
☐Yes ☐No Calf Pain With Walking
☐Yes ☐No Calf Pain With Rest/At Night
☐Yes ☐No Clotting Disorder
☐Yes ☐No Poor Circulation (PVD)
☐Yes ☐No Varicose Veins
☐Yes ☐No Venous Insufficiency

Neurologic

☐Yes ☐No Charcot
☐Yes ☐No Dementia/Alzheimer's
☐Yes ☐No Neuropathy
☐Yes ☐No Stroke
☐Yes ☐No Seizures

Other

☐Yes ☐No Cancer (Type _____)
☐Yes ☐No Hepatitis (A, B, C)
☐Yes ☐No HIV / AIDS

Abdomen/Gastrointestinal/Urinary

☐Yes ☐No Cirrhosis
☐Yes ☐No Gastrointestinal Bleeding
☐Yes ☐No Heart Burn, Reflux
☐Yes ☐No Incontinence
☐Yes ☐No Kidney Failure
☐Yes ☐No Kidney Stones
☐Yes ☐No Liver Disease
☐Yes ☐No Stomach Ulcers
☐Yes ☐No Urinary Tract Infections

Orthopedic

☐Yes ☐No Arthritis (Location:_____)
☐Osteoarthritis ☐Rheumatoid ☐Gout ☐Psoriatic
☐Yes ☐No Back Pain/Problems
☐Yes ☐No Fracture (Location:_____)
☐Yes ☐No Joint Pain
☐Yes ☐No Osteoporosis
☐Yes ☐No Muscle Weakness

Endocrine

☐Yes ☐No Diabetes
☐ Oral Med ☐ Insulin ☐ Diet Controlled
☐Yes ☐No Pituitary Disease
☐Yes ☐No Thyroid Disease (Low or High)

Psychological

☐Yes ☐No Anxiety
☐Yes ☐No Bipolar Disorder
☐Yes ☐No Depression
☐Yes ☐No Schizophrenia

Cardiac

☐Yes ☐No Angina
☐Yes ☐No Atrial Fibrillation
☐Yes ☐No Congestive Heart Failure
☐Yes ☐No Coronary Disease
☐Yes ☐No Heart Disease
☐Yes ☐No High Blood Pressure
☐Yes ☐No High Cholesterol
☐Yes ☐No MI/heart attack
☐_____ (year)
☐Yes ☐No Murmur/Irregular Beat
☐Yes ☐No Pacemaker
☐Yes ☐No Valve Disorder

Pulmonary

☐Yes ☐No COPD
☐Yes ☐No Emphysema
☐Yes ☐No Pneumonia

Dermatologic

☐Yes ☐No Cellulitis
☐Yes ☐No Chronic Wounds
☐Yes ☐No Dry Skin
☐Yes ☐No Eczema
☐Yes ☐No Psoriasis
☐Yes ☐No Swelling

Any Other Condition You Are Being Treated For?

__

Surgical History

Surgery	Date	Physician

Do You Have Any Metallic Implants or Foreign Bodies In Your Body? ☐Yes ☐ No If Yes Please Describe:_____

Family History

Does Anyone In Your Family Have History Of The Following? If Yes, List Who (Mother, Father, Grandparent, Siblings, Aunt, or Uncle)

☐Asthma_____ ☐Cancer_____ ☐Diabetes_____ ☐Heart Disease_____
☐High Cholesterol_____ ☐Hypertension _____ ☐Liver Disease_____ ☐Mental Illness_____
☐Lung Disease_____ ☐Kidney Disease_____ ☐Stroke _____ ☐Vascular Disease _____

Do You Have or Are You Having Any of the Following **TODAY or in the Past 6 months**? Check (☑) All That Apply

☐Weight Loss/Gain
☐Fatigue
☐Fever ☐Chills
☐Constipation
☐Diarrhea
☐Rectal Bleeding
☐Frequent Urination
☐Blood in Urine
☐Incontinence
☐Painful Urination
☐Swallowing Difficulties
☐Change in Appetite
☐Nausea
☐Vomiting
☐Heartburn

☐Cramping of Calf/Leg
☐Bleed Easily
☐Varicose Veins
☐Muscle Pain
☐Joint Pain
☐Back Pain
☐Joint Stiffness
☐Redness of Joints
☐Weakness
☐Dizziness
☐Numbness
☐Tingling
☐Tremor
☐Fainting
☐Increased Thirst

☐Abnormal Sweating
☐Heat/Cold Intolerance
☐Rash
☐Itching
☐Skin Color Changes
☐Lumps/Masses
☐Skin Dryness
☐Nail Changes
☐Headache
☐Sinus Pain
☐Decreased Hearing
☐Ringing In Ears
☐Earache
☐Blurry or Double Vision
☐Cataracts

☐Visual Difficulty
☐Nervousness
☐Anxiety
☐Depression
☐Memory Loss
☐Cough
☐Shortness of Breath
☐Wheezing
☐Chest Pain
☐Swelling of Limbs
☐Palpitations
☐Heart Racing