POTOMAC PODIATRY GROUP, PLLC

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Date:_____/_____/_____ Name:_____

DOB:_____/_____/_____ Height:_____ Weight:_____ Gender: ☐Male ☐Female

Phone Number:_____ Email Address:_____

Primary Care Physician Name:_____ Date Last Seen:_____/_____/_____

Pharmacy Name/Zip code:_____

Has your insurance changed since your last visit? ☐Yes ☐No

If yes please let us know of the changes:

_____

_____

Why are you coming to see us today?_____

Any changes in ALLERGIES: ☐Yes ☐No

If yes, explain:_____ Reaction: _____

Any changes in MEDICATIONS (INCLUDE PRESCRIPTIONS, OVER THE COUNTER & VITAMINS)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Any RECENT MEDICAL VISITS

Are you now, or have you been, under any other doctors' care for any reason over the past two years? ☐ Yes ☐ No

If yes, please explain:

_____

_____

_____

_____

Any RECENT SURGERIES

☐ No prior surgical history	☐ Laparoscopy	☐ Endometrial Ablation
☐ Appendectomy	☐ Mastectomy	☐ Gall Bladder
☐ Breast Lumpectomy	☐ Myomectomy	☐ Heart Surgery
☐ Cataract Surgery	☐ Oophorectomy	☐ Hemorrhoids
☐ Colectomy	☐ Stents in Lower Extremity	☐ Hernia
☐ Cone Biopsy	☐ Tonsil/Adenoidectomy	☐ Hysterectomy
☐ D & C	☐ Tubal Ligation	
☐ Other _____		

SOCIAL HISTORY Changes

Tobacco User? □ Yes □ No

Smoking Status? □ Never Smoker □ Current Smoker every day □ Current Some Day □ Heavy Tobacco Smoker
□ Light Tobacco Smoker □ Former Smoker □ Unknown if ever smoked

If yes, how many packs per day?: _____ How many years?: _____

Do you drink alcohol? □ Yes □ No _____ Drinks per _____ (day, week, month, year)

Have you used drugs such as LSD, Marijuana, Methamphetamines, Cocaine or Heroin in the past 2 years? □ Yes □ No

MEDICAL HISTORY Changes

□ Diabetes	□ PAD Circulation Problems	□ Neuropathy
□ Heart Disease	□ HIV	□ Lower Back Problems
□ Stroke	□ Arthritis	Other: _____
□ Cholesterol	□ Lupus	Other: _____

Benefits & Privacy Policy for Potomac Podiatry Group

ASSIGNMENT OF BENEFITS/PRIVACY POLICY

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Potomac Podiatry Group all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions. I authorize Potomac Podiatry Group to use the Health Information Exchange Network in order to provide more comprehensive medical treatment.

By my signature I acknowledge reviewing the financial and privacy policies and hereby agree to their terms.

*Printed Name:*_____

*Signature:*_____ *Date:* _____

I acknowledge receiving ***Potomac Podiatry Group's*** *Notice of Privacy Practices (posted in the office and on the website).*

*Signature:*_____ *Date:*_____

I authorize the following individuals to receive information on my behalf. This includes medical information.

*Name & Relationship:*_____

*Name & Relationship:*_____

*Name & Relationship:*_____

Crofton Foot and Ankle
www.CroftonPodiatry.com
P: 410.721.4505 | Fax: 410.721.2394
1657 Crofton Blvd, Suite 201, Crofton, MD 21114

Family Foot Care Center
www.TheFamilyFootCareCenter.com
P: 301.645.1406 | Fax: 301.645.0997
4475 Regency Place, Suite 204, White Plains, MD 20695

Annapolis Foot and Ankle
www.AnnapolisFootandAnkle.com
P: 410.263.3100 | Fax: 410.263.7380
43 Old Solomons Island Rd, Suite 102, Annapolis, MD 21401

Potomac Podiatry Group
www.PotomacPodiatryGroup.com
P: 703.583.5959 | Fax: 703.583.5995
14010 Smoketown Rd, Suite 103, Woodbridge, VA 22192

Loudoun Foot and Ankle Center
www.LoudounFootandAnkleCenter.com
P: 703.444.9555 | Fax: 703.444.1190
46440 Benedict Dr, Suite 209, Sterling, VA 20164