

HEALTH HISTORY FOR ARLINGTON FOOT AND ANKLE

Patient Name _____ Referred by Doctor: _____
 How did you hear about our office? _____ e-mail address _____
 Age: _____ Allergies: _____ Chief complaint: _____
 Location: _____ Date of injury: _____ Duration: _____ Severity: _____ (Scale 1-10)
 Timing: _____ Previous/Home treatment: _____
 (Does the pain/problem occur at a specific time)

PAST MEDICAL HISTORY (Have you ever had the following: Please check all that apply.)

- | | | |
|--------------------------|---------------------------|---------------------------------|
| Anemia _____ | Back trouble _____ | Infectious Mono _____ |
| Bladder Infections _____ | High Blood Pressure _____ | Bronchitis _____ |
| Epilepsy _____ | Low Blood Pressure _____ | Mitral Valve Prolapse _____ |
| Migraine Headaches _____ | Hemorrhoids _____ | Tuberculosis _____ |
| Kidney Disease _____ | Diabetes _____ | Asthma _____ |
| Cancer _____ | Hives/Eczema _____ | Bleeding Tendency _____ |
| Polio _____ | AIDS or HIV+ _____ | Hepatitis _____ |
| Rheumatic Fever _____ | Glaucoma M _____ | Blood/Plasma transfusions _____ |
| Heart Disease _____ | Hernia _____ | Thyroid Disease _____ |
| Arthritis _____ | Venereal Disease _____ | |
-
- | | | |
|---|---------------------------------|--|
| Constitutional Symptoms | Genitourinary | Neurological |
| Good general health lately _____ | Frequent urination _____ | Frequent/recurring headaches _____ |
| Recent weight change _____ | Burning/painful urination _____ | Light headed/dizzy _____ |
| Fever _____ | Blood in urine _____ | Convulsions/seizures _____ |
| Fatigue _____ | | Numbness/tingling sensations _____ |
| Headaches _____ | Musculoskeletal | Tremors _____ |
| Muscle weakness _____ | Joint pain _____ | Paralysis _____ |
| | Joint stiffness/swelling _____ | Head injury _____ |
| Eyes | Difficulty walking _____ | |
| Eye disease/injury _____ | Integumentary | Endocrine |
| Wear glasses/contacts _____ | Rash/itching _____ | Glandular/hormone problems _____ |
| Blurred/double vision _____ | Change in skin color _____ | Excessive thirst/urination _____ |
| | Change in hair/nail color _____ | Skin becoming dryer _____ |
| Cardiovascular | Varicose veins _____ | Hematological/Lymphatic |
| Heart trouble _____ | Breast pain _____ | Slow to heal after cuts _____ |
| Chest pain/angina pectoris _____ | Breast lump _____ | Phlebitis _____ |
| Palpitation _____ | Breat discharge _____ | |
| Shortness of breath w/ walking _____ | Psychiatric | Date of last chest x-ray _____ |
| Swelling of feet, ankles or hands _____ | Memory loss/confusion _____ | Any other diseases (please list): |
| Respiratory | Nervousness _____ | _____ |
| Chronic/frequent coughs _____ | Depression _____ | _____ |
| Spitting up blood _____ | Insomnia _____ | |
| Wheezing _____ | | |

| Previous Hospitalizations/Surgeries/Serious Illness | When? | Hospital, City, State |
|---|-------|-----------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Medications: (Include non-prescription) _____

Patient Social History
 Marital status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____
 Use of alcohol: Never _____ Rarely _____ Moderate _____ Daily _____
 Use of tobacco: Never _____ Previously, but quit _____

Family Medical History

| | Age | Diseases | If Deceased cause of death |
|----------|-------|----------|----------------------------|
| Father | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ |
| Siblings | _____ | _____ | _____ |

**WELCOME TO
ARLINGTON FOOT AND ANKLE CENTER
AARON BEN PEARL
1715 N. GEORGE MASON DRIVE, SUITE 407
ARLINGTON, VA. 22205**

| | | | | | |
|------------------------------------|------------|--------------|-----------------|-------------------|-----|
| LAST NAME MIDDLE FIRST | | | BIRTHDATE | AGE | SEX |
| STREET ADDRESS | | CITY | | STATE | ZIP |
| HOME PHONE | WORK PHONE | EXT. | ALT. PHONE/CELL | SOCIAL SECURITY # | |
| EMERGENCY CONTACT/NEXT OF KIN NAME | | RELATIONSHIP | PHONE | | |
| PRIMARY CARE PHYSICIAN NAME | | PHONE | DATE LAST SEEN | | |

ALLERGIES TO MEDICATION

| |
|--------------|
| PLEASE LIST: |
|--------------|

ASSIGNMENT OF BENEFITS

I understand that I am responsible for payment in full of all charges. I authorize payment of benefits from my insurance to be paid directly to Aaron Ben Pearl, D.P.M. I also authorize Aaron Ben Pearl, D.P.M. to release to my insurance company any and all information necessary for the processing of insurance claims.

Signature: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES/HIPPA

I have had the opportunity to review and/or receive a copy of the Notice of Privacy/HIPPA compliance policies of Arlington Foot and Ankle Center.

Signature: _____

Patient Financial Policy

We are dedicated to providing the best possible care and service to you and regard your complete understanding our financial policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.

Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, cash or check.

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/coinsurance/deductible at the time of service

If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis, this means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

You must inform the office of all insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility

There are certain elective surgical procedures that we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.

Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.

There is a service fee of \$25.00 for all returned checks. Your insurance company does not cover this fee.

FEE FOR BROKEN APPOINTMENTS: Broken appointments will incur a charge of \$35.00 unless 24-hour notice is given. This is a fee that the patient (not insurance) is responsible. This charge may be waived in certain circumstances by management only.

Signature of Patient/Responsible Party:

Printed Name: _____ Date: _____

Signature: _____

EFFECTIVE OCTOBER 1, 2005

An administrative fee of \$5.00 will be assessed for every bill sent out over 30 days past due. All accounts over 90 days past due will be turned over to collections and a 30% collection fee will be assessed. Thank you in advance for your prompt payment of your bill.

Signature

Print

Date