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WE ARE VERY PLEASED TO WELCOME YOU TO OUR OFFICE. PLEASE ANSWER THESE QUESTIONS TO HELP US BECOME ACQUAINTED. IF YOU NEED HELP, PLEASE ASK US.

PATIENT'S NAME: First _____ Middle _____ Last _____			SPOUSE'S NAME _____	
HOME ADDRESS: Street _____ City _____ State & Zip _____			HOME PHONE _____	
EMPLOYED BY _____ ADDRESS _____			WORK PHONE _____ EXT. # _____	
SPOUSE/PARENT EMPLOYED BY _____ ADDRESS _____ PHONE _____			PT. BIRTHDATE _____	SEX _____
PATIENT SOCIAL SECURITY NO. _____	PATIENT OCCUPATION _____	HEIGHT _____	WEIGHT _____	AGE _____
WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE? _____			MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widow	
IN CASE OF EMERGENCY, CONTACT _____			RELATIONSHIP _____ PHONE _____	
FINANCIALLY RESPONSIBLE PERSON <input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other		NAME AND ADDRESS IF DIFFERENT FROM PATIENT _____		HOME PHONE _____
				WORK PHONE _____
SUBSCRIBER INFORMATION	NAME & ADDRESS OF SUBSCRIBER IF DIFFERENT FROM PATIENT _____			
	DATE OF BIRTH _____	RELATIONSHIP TO PATIENT _____	SUBSCRIBER'S SOCIAL SECURITY NO. _____	HOME PHONE _____
PRIMARY INSURANCE CO.		MEDICARE		
Ins. Co. Name: _____		I.D. No.: _____		
Address: _____		Effective Date: _____		
I.D. No.: _____		SEND INSURANCE FORM TO: Who approved treatment: _____		
Group: _____				
Subscriber: _____ (PERSON'S NAME)				
HMO Plan I.D. No.: _____				
PPO Plan I.D. No.: _____				
Phone No.: _____				
Effective Date: _____				
SECONDARY INSURANCE CO.		WORKMAN'S COMPENSATION		
Ins. Co. Name: _____		Ins. Co. Name: _____		
Address: _____		Address: _____		
I.D. No.: _____		I.D. No.: _____		
Group: _____		Group: _____		
Code: _____		Date of Injury: _____		
Subscriber: _____ (PERSON'S NAME)		Subscriber: _____ (PERSON'S NAME)		
Effective Date: _____		Phone No.: _____		
		Effective Date: _____		

Patient's Authorization

I, _____, hereby authorize Douglas E. Stabile, D.P.M., P.C. to apply for benefits on my behalf for covered services rendered by Douglas E. Stabile, D.P.M., P.C., and request that the payments from Blue Cross/Blue Shield of National Capital Area/Blue Shield of Virginia/Medicare and/or _____ (OTHER INS. CO. NAME) be made directly to Douglas E. Stabile, D.P.M., P.C. (or in case of Medicare Part B benefits, to myself or to the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above named billing agent, Blue Cross/Blue Shield of National Capital Area/Blue Shield of Virginia (or in case of Medicare Part B benefits, to the Social Security Administration and Health Care financing Administration)/Medicare and/or _____ (OTHER INS. CO. NAME). I permit a copy of this authorization to be used in place of the original.

This authorization may be revoked by either me or the above named carrier at any time in writing.

PATIENT ACCOUNT NO. _____

SIGNATURE OF SUBSCRIBER OR BENEFICIARY _____ IDENTIFICATION NO. _____ DATE _____

PLEASE NOTE:



Services are rendered to you, the patient. Responsibility for payment to this office is with you, the patient, not the insurance company. This form has been specifically designed to assist in the completion of your insurance form. Our office, however, cannot accept the responsibility for collecting your insurance claim or negotiating reimbursement schedules.

Please turn to the back of this page and answer all questions. This information is important to your health and records.

CHIEF CONCERN/PRESENT ILLNESS:

What is your present foot/ankle problem? _____

How long have you been bothered by the above? _____

What have you done for your foot/ankle problem? _____

PAST MEDICAL HISTORY:

Family doctor's name: _____

Doctor's Address: _____ Phone: _____

Are you now or have you been under a physician's care during the past two years? Yes No

Date of last complete physical exam: _____

Are you presently taking any medicine? Yes No If yes, what? _____

Check if you presently have or were treated for:

- High blood pressure
- Epilepsy
- Gout
- Arthritis
- Kidney disease
- Broken bones
- Previous foot/ankle condition
- Diabetes
- Liver trouble
- Anemia
- Bleeding tendency
- Asthma
- TB
- Heart Disease
- Cancer
- Glaucoma
- Ulcers
- Nervous condition
- Allergies
- Other: _____
- Stomach problems
- Seizures
- Phlebitis
- Sickle Cell Disease/Trait

Medications allergic to: Aspirin Codeine Novocaine Xylocaine Iodine Adhesive Tape
 Penicillin Other: _____

Do you smoke? Yes No

Have you had surgery? Yes No TYPE _____ Year _____
TYPE _____ Year _____

(WOMEN) ARE YOU PREGNANT? Yes No If yes, when are you expecting? _____

FAMILY HISTORY

Circle if any blood relatives have had

Arthritis Cancer Diabetes Heart Disease High blood pressure Kidney disease Overweight

Foot problems similar to yours _____

Is there any other general or foot health information that should be known? _____

I HEREBY GIVE PERMISSION TO DR. STABILE/DR. DERNER/DR. SCRIPPS TO EXAMINE, DIAGNOSE AND TREAT MY FEET MEDICALLY, OR SURGICALLY AND ATTEST THAT THE ABOVE INFORMATION IS ACCURATE AND TRUE.

PATIENT (PARENT/GUARDIAN) SIGNATURE _____ DATE _____

THANK YOU FOR YOUR COOPERATION