Dr. Ayne Furman
(703) 549-4409
209 Commerce St
Alexandria, VA.

# ARCH AND SOLE PODIATRY CENTER

## Patient Information Form

Today's Date:

Patient Information

NAME: LAST________________________ M.I._____ FIRST____________

How do you prefer being referred to?______________ Date of birth_______

Address:__________________________________ City______________

State_____

Zip Code______________ Email:____________________________

Home #_________________ Cell # _______________ Work #_________

Can phone messages be left on all the above numbers?

Sex: Male Female Status: Married Single Divorced Other

Employer's Name:__________________ Occupation:_______________

Spouse's or S.O. Name:____________________________

Can information regarding what Dr. Furman is treating you for be discussed with the above person? Yes No

In case of an emergency, contact:________________

Relationship____________

Phone #________________

How were you referred to Dr. Furman ?______________

What is the chief complaint that brings you to the office today?______________

What is the name of your family physician?_____________

Medical History

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Height: Weight:

Have you had or currently have any of the below conditions? Check all that apply:

____Anemia ____Epilepsy/Seizers ____Heart Condition ____Arthritis (not rheumatoid)

___Rheumatoid or other auto-immune type of arthritis

___Lyme's Disease ___Fibromyalgia ____Chronic Fatigue syndrome

___Cancer ____Diabetes ___Blood clots (if yes, where was the clot?______)

____Bleeding problems ____Breathing problems ____Heart Condition

____High Blood Pressure ____Infectious disease ____Kidney trouble

____Liver trouble ____Stroke

____ Stomach ulcers ____Joint replacement (Hip or Knee)

If you checked "yes" to any of the above, please explain if necessary:

Any operations? Yes No

Please list with approximate dates (except for foot surgeries):

If female, are you pregnant? _____________

Have you ever broken any bones? If yes, please list with approximate dates:

Do you smoke? Yes No Do you consume alcohol? Yes No

Please list medication you are currently taking:__________________________________________

Please list any allergies:

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____None ____Anti-inflammatory medications (aspirin or Motrin type drugs)

____Codeine ____Cortisone ____Iodine ____Penicillin

____Metals (nickel, copper) ____Sulfa drugs ____Tape

____Latex or dyes ____Other medications

Type of reaction/s experienced:

Patient or Parent of patient signature________________ Date:________

Activity Profile:

I consider myself: Very active Moderately active Sort of active Sedentary

What fitness or athletic activities do you regularly participate in? How often? How many times a week? Check all that apply:

| approximate # of times/wk | approximate # of times/wk |
| --- | --- |
| ____Running | ____Dancing |
| ____Walking | ____Aerobic dancing |
| ____Walk the dog | ____Yoga |
| ____Tennis | ____Golf |
| ____Cycling/spin class | ____Weight training |
| ____Other:_________ | |

In the last year have you had to stop activity for more than a week due to a foot, ankle, leg or knee pain or injury?

Do you regularly use a personal trainer? Yes No

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Podiatric History:

Are you presently being treated by another health professional for this presenting problem? Yes No If yes, who?

Do you or have you ever used custom orthotics or foot levelers?

Have you ever been treated for a foot, ankle or leg injury or pain in the past?

If yes, what was the diagnosis? Plantar fasciitis shin splints sprained ankle neuroma uneven leg length heel spur bunion

Have you ever had foot surgery? If yes, what type and when?

____Bunionectomy ____Hammertoe surgery ____Neuroma surgery

____Metatarsal surgery ____Heel spur surgery

____Been treated for a foot ulcer

Is there personal or family history of diabetes? Yes No - Who?

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Financial and Insurance Information

It has been explained to me that this is a fee for service practice. Payment is due at the time of service. Dr. Furman will supply me with the necessary forms and information to file a claim with my insurance company and/or MSA (medical savings account).

Dr. Furman is not responsible for knowing the terms of my insurance coverage or specific details regarding reimbursement coverage.

Dr. Furman is not a participating provider or in any contractual arrangement with any insurance carrier.

If I am a Medicare beneficiary I have been notified, and it has been explained to me that Dr. Furman does not participate with Medicare. This is referred to as *opt-out*. If you are a Medicare beneficiary charges for services preformed by Dr. Furman will be denied payment by Medicare.

Patient's signature________________________ Date_________

Patient's name___________________________

Consent to treatment:

I hereby consent and give Dr. Ayne Furman my permission to administer and perform such procedures upon me as she deems necessary.

Signature of patient, parent or guardian_____________________ Date:_____

Relationship to patient:_________________