FAIRFAX FOOT AND ANKLE CENTER, PC
ROSTANA SAID, D.P.M.
RAYMOND J. OLKIN, D.P.M
www.fairfaxfootandanklecenter.com

FAIRFAX MEDICAL CENTER
10721 MAIN ST, SUITE 103
FAIRFAX, VA 22030
Phone (703) 273-3622
Fax (703) 273-0313

PATIENT REGISTRATION FORM **DATE: _____**

• Patient Information

First Name: _____
Middle Initial: ____
Last Name: _____
Gender: Male: _____ Female: _____
Date of Birth: _____ Age: _____
Marital Status: _____
Ethnicity: _____Language: _____
Race: _____SSN: _____-_____-_____
Patient's Occupation: _____
Address: _____
_____Apt: _____
City: _____ Zip: _____
Home: ( ) _____
Cell: ( ) _____
Work: ( ) _____
E-mail: _____
Pharmacy: _____
Phone ( ) _____
Address: _____

•How did you hear about us?

InsCo: __ Web: __ Friend: __ Walk in: __ Other: __

• **Parent/ Guardian:** If patient under 18 years old

First Name: _____
Middle Initial: _____
Last Name: _____
Address: _____
_____Apt: _____
City: _____Zip:_____

Home: ( ) _____
Cell: ( ) _____
Work: ( ) _____
SSN: _____-_____-_____DOB: _____
Relationship to patient: _____

•Emergency Contact

Name: _____Relation: _____
Phone: ( ) _____

•Insurance Information

Primary Insurance: _____
Policy Holder: First Name: _____
Middle Initial: _____
Last Name: _____
DOB: _____
SSN: _____
Relationship to Pt: _____
Member ID: _____
Group Number: _____
Ins Co Address: _____
Employer: _____

Secondary Insurance: _____
Policy Holder: First Name: _____
Middle Initial: _____
Last Name: _____
DOB: _____
SSN: _____
Relationship to Pt: _____
Member ID: _____
Group Number: _____
Ins Co Address: _____
Employer: _____

What is your present foot problem: _____

How long have you been bothered by this problem: _____

What have you done for this problem :_____

Is your foot problem the result of an accident: _____,If yes, date of accident:_____

Is there any other general foot health information that we should know about: _____

Medical History

Family doctor's name: _____ Office phone: _____
Address: _____City: _____State: _____Zip:_____

Are you currently, or have you been under a physician's care in the past two years ◯Yes ◯ No

Date of last physical exam: _____ Are you presently taking any medications ◯ Yes ◯No

If yes, name and dosage of medications: _____
_____

Have you ever tested positive for Human Immunodeficiency Virus (HIV) ◯Yes ◯No
Do you smoke ◯Yes ◯ No

Check if you have been treated for any of the following:

◯ High Blood Pressure	◯ Circulation problem	◯ Cancer	◯ Arthritis
◯ Nervous Condition	◯ Broken Bones	◯ Anemia	◯ Gout
◯ Kidney Disease	◯ Heart Disease	◯ Hepatitis	◯ Epilepsy
◯ Bleeding tendency	◯ Diabetes	◯ Asthma	◯ Allergies
◯ Liver trouble	◯ TB	◯ Ulcers	◯ Glaucoma

◯ Other: (please specify): _____

Have you ever experienced any unusual or allergic reactions to any medications (e.g., Novocain, Penicillin, etc.) ◯ Yes ◯ No
If so, which one: _____
What was the reaction: _____
Past Surgeries/ Year: _____
_____

Family History of:	◯ Arthritis	◯ Cancer	◯ Diabetes
◯ Heart Disease	◯ High Blood Pressure	◯ Kidney Disease	◯ Obesity

◯ Foot problem similar to yours

Virginia law requires us to inform you that your blood may be tested for the HIV (AIDS) virus if any health care worker is accidentally exposed to your blood in a manner that could transmit HIV infection. Your consent is NOT needed, but you will be informed if tested.

PATIENT AUTHORIZATION:

I hereby authorize Fairfax Foot and Ankle Center to release to my insurance and primary care physician any information acquired in any examination or treatment.

ASSIGNMENT OF BENEFITS:

I request that payment of authorized insurance benefits be made to Fairfax Foot and Ankle Center for services furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits payable for related service.

MEDICARE PATIENTS:

This office accepts Medicare assignment. Medicare patients are fully responsible, however, for the initial yearly deductible and the 20% co-payment. Federal law requires that physicians collect this amount.

I also understand that I am fully responsible for any charges incurred, and filing of claims on my behalf by Fairfax Foot and Ankle Center is done purely as a courtesy. And I am fully responsible for any charges my insurance deems as a patient's responsibility. I understand that a $30.00 fee, plus court costs and a 33.3% attorney fee and court costs will be added to my account for any unpaid balances that are sent to the attorney for collection.

APPOINTMENT CANCELLATION POLICY:

Fairfax Foot and Ankle Center, PC., requires 24 hours advance notice for any office appointment cancellation/ re-scheduling. A charge of $25.00 dollars will be posted to your account in the event you fail to cancel or, re-schedule your appointment before 24 hours, this charge is NOT covered by any insurance company and, it is a patient's responsibility.

VOICE MAIL MESSAGES AUTHORIZATION/ CONSENT:

Please provide a working telephone number where detailed voice mail messages can be left for your review: Phone Number ( )

_____

_____

PATIENT SIGNATURE: _____

DATE: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I acknowledge that I was provided (Upon request only) a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the Notice posted on the wall.

PATIENT SIGNATURE: _____

DATE: _____

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INSURANCE PARTICIPATION NOTIFICATION.

Fairfax Foot and Ankle Center, PC. does not participate with many of the Affordable Care Act insurance plans. Your health insurance is a contract between you, your employer and the insurance company. Therefore, it is the patient's responsibility to know if the providers are "in network" with their insurance plans before any scheduled visits.

While the practice makes every effort to help you determine your coverage, we are not party to many of these contracts. Therefore, if you are seen by any of our providers with "out of network" benefits for your particular insurance plan, you will be responsible for payment of all charges to Fairfax Foot and Ankle Center, PC.

Our practice ID: 54-1947398, is provided for your convenience to check on benefits for your specific plan. Provide this number to your insurance representative at the time you check coverage benefits.

I have read and understand that my insurance plan may not be "in network" with Fairfax Foot and Ankle Center, PC. I accept full financial responsibility for the cost of this service if uncovered by my insurance carrier.

_____ _____

Patient's Name **Date**

_____

Signature