

THE PODIATRY GROUP
600 PETER JEFFERSON PARKWAY, SUITE 360
CHARLOTTESVILLE, VIRGINIA 22911

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WELCOME TO OUR OFFICE

Today's Date: _____ Chart Number: _____

Full Name: _____ Name You Wish To Be Called: _____

Address: _____ City/State/Zip: _____

Social Security Number: _____ Age: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____ Email Address: _____

Sex: Male _____ Female _____ Spouse's Name: _____ Spouse's Birthdate: _____

Spouse's SSN: _____ Marital Status: Single _____ Married _____ Widowed _____ Divorced _____

If a child, name of responsible party (please print): _____

Employed by: _____ Occupation: _____ Phone: _____

Family Physician: _____ Phone: _____

Referred By: _____ Last Visit: _____

Do you smoke? _____ Yes _____ No If so, how long? _____

List Any Previous Surgeries: _____

List Any Medication Allergies: _____

List Any Medications You Are Presently Taking: _____

Are You Pregnant or Breastfeeding? _____

State, In Your Own Words, Your Reason For Coming To Our Office: _____

Date of Injury/Accident: _____ Work Related: _____ Yes _____ No

Have You Ever Had (Circle YES or NO)

Diabetes.....Yes	No	Heart Problems.....Yes	No	Rheumatic Fever.....Yes	No	Gout.....Yes	No
Stroke.....Yes	No	Leg Cramps.....Yes	No	High Blood Pressure.....Yes	No	Cancer.....Yes	No
Epilepsy.....Yes	No	Liver Problems.....Yes	No	Bleeding Tendencies.....Yes	No	Asthma.....Yes	No
Glaucoma.....Yes	No	Tuberculosis.....Yes	No	Peripheral Neuropathy.....Yes	No	Hepatitis....Yes	No
Anemia.....Yes	No	Stomach Ulcers.....Yes	No	Peripheral Vascular Disease.....Yes	No	Phlebitis.....Yes	No
Arthritis.....Yes	No	Varicose Veins.....Yes	No	Venereal Disease.....Yes	No	HIV.....Yes	No

Other Medical Conditions Not Listed Above: _____

Primary Insurance Company: _____ Policy No.: _____

Insured's Name: _____ Insurance Phone No.: _____

Secondary Insurance Company: _____ Policy No.: _____

Insured's Name: _____ Insurance Phone No.: _____

Referral Required? _____ Yes _____ No Referral Obtained From Referring Physician? _____ Yes _____ No

AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION: I hereby give The Podiatry Group permission to treat my feet and/or ankles. I request that payment of authorized Medicare and/or other insurance company benefits be made to The Podiatry Group for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, and any other insurance company involved, any information needed to determine these benefits payable for related services. I understand that I am responsible for any unpaid portions.

Signature of Patient or Legal Guardian _____ Date: _____