

JIMMY W. DOWNING D.P.M

THE PODIATRY GROUP 600 PETER JEFFERSON PARKWAY, SUITE 360 CHARLOTTESVILLE, VIRGINIA 22911
434-979-0763 (office) 434-979-8681 (fax)

PATIENT REGISTRATION

Today's Date: _____

Chart No: _____

Full Name: _____

Name you wish to be called: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

E-mail address: _____

SS#: _____ DOB: _____ Race: _____ Sex: _____

Marital Status: _____ Spouse's Name: _____ Spouse's DOB: _____

Employer: _____ Position: _____ FT PT Unemployed Retired

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

Family Physician: _____ Referring Physician: _____

Emergency Contact: _____ Relationship to patient: _____

Pharmacy: _____

I _____, hereby authorize Dr. Jimmy W. Downing, The Podiatry Group to treat my feet and/or ankles. I request that payment be made to Dr. Jimmy W. Downing/The Podiatry Group for any services rendered to by the physician. I further authorize the release of any necessary medical or other information for this or any related claim to my insurance company. This will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by insurance. I agree to assume responsibility for all charges incurred should collection of this balance become necessary including court cost, collection agency fees, and attorney fees.

Signature of Patient or Legal Guardian

Date: _____

OVER →

JIMMY W. DOWNING, DPM

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HEALTH QUESTIONNAIRE

PERSONAL DATA:

Name: _____ Age: _____

Family Physician: _____ Phone #: _____

CHIEF COMPLAINT: What is the reason for your visit today? _____

When did this problem start? _____ Work Injury Auto Accident Other

Have you ever had these symptoms or similar symptoms in the past _____

Previous medical care for this condition _____

Previous surgeries on lower extremity _____

Indicate work status: _____

Is your pain: constant intermittent sharp dull stabbing burning other _____

Do you experience: numbness cramping tingling other _____

What activities or motions increase your symptoms? _____

What activities or motions decrease your symptoms? _____

Medications: _____

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

Allergies: _____

PAST MEDICAL HISTORY:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> anemia | <input type="checkbox"/> gout | <input type="checkbox"/> lung disease/asthma | <input type="checkbox"/> venereal disease |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> heart attack | <input type="checkbox"/> neurologic disorders | <input type="checkbox"/> other |
| <input type="checkbox"/> bleeding tendencies | <input type="checkbox"/> heat disease | <input type="checkbox"/> pinched nerves | _____ |
| <input type="checkbox"/> blood clots | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> peripheral neuropathy | _____ |
| <input type="checkbox"/> cancer | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> peripheral vascular disease | _____ |
| <input type="checkbox"/> coronary artery disease | <input type="checkbox"/> joint replacement | <input type="checkbox"/> rheumatic fever | |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> kidney disease | <input type="checkbox"/> stroke | |
| <input type="checkbox"/> epilepsy | <input type="checkbox"/> leg cramps | <input type="checkbox"/> tuberculosis | |
| <input type="checkbox"/> fracture | <input type="checkbox"/> liver problems | <input type="checkbox"/> ulcers | |

Please mark where you are experiencing pain: RT LT Both

