|  |  |
| --- | --- |
|  | **Roger W. Lidman, M.D., F.A.C.P.**  **Witold A. Turkiewicz, M.D.**  **John V. Mansoor, M.D.**  **Julianne S. Orlowski, D.O.**  **Megan E. Eshbaugh, D.O., F.A.C.O.I.** |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Welcome to the Center for Arthritis and Rheumatic Diseases, P.C.

This is to confirm your appointment with Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at \_\_\_\_\_\_\_\_\_\_\_ AM/ PM on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in our \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ office.

Directions to each office are attached for your convenience. To ensure all forms are completed and ready for your physician’s review, please arrive at least 30 minutes early.

When you come in, it is very important to bring the attached PATIENT HISTORY FORM completed, with any x-ray films, blood test results, or other results, your insurance card(s), photo ID, and the referring doctor’s full name and address. These are very important for your medical record.

Please note, our practice does not perform pain management. Our providers will evaluate for any rheumatologic diseases and will work closely with your primary care physician. Center for Arthritis takes pride in the importance that we place on being part of a health care team. We require that patients have seen their primary care provider within one year of their appointment at our office.

You may be contacted by our billing department prior to your visit to verify your insurance coverage. We file your insurance for you, and a patient account representative will be assigned to you to help with your billing needs. Since your insurance company may not cover the entire cost of your visit, we do require payment at the time of service. If any of your insurance information changes, please contact our billing office at (757) 461-6997.

**We will try to call you two days in advance of this appointment to confirm, and we must hear back from you within 24 hours of your appointment. Regardless of whether we are able to reach you to confirm, it is your responsibility to contact us to confirm this appointment; otherwise, your appointment will be cancelled and given to another new patient. You must speak directly with the front desk to confirm your initial appointment. Do not leave a message as confirmation. A $150.00 charge will be added to your account for failure to keep your new patient confirmed appointment.**

We appreciate your cooperation and look forward to your visit. If you have any questions, please contact the office where your appointment is scheduled; the numbers are listed below.

Thank You,

The Center for Arthritis & Rheumatic Diseases, P.C.

**PATIENT HISTORY FORM**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthday: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_

Nickname/ Name you go by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Place: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: Single Married Divorced Widowed

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M/ F

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Insurance**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Subscriber DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Subscriber Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Next of Kin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you to us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The name of the physician providing your primary medical care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have an orthopedic surgeon? \_\_\_\_ Y/ \_\_\_ N If yes, Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Main symptoms and Reasons for coming to see the doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date symptoms began (approximately): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list the names of other practitioners you have seen for this problem: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I AFFIRM THAT THE INFORMATION ABOVE IS ACCURATE AND TRUE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES INCURRED FOR THE ABOVE NAMED PATIENT. I AGREE TO PAY ANY COSTS OF COLLECTIONS IF NECESSARY. I AUTHORIZE TREATMENT FOR THE ABOVE NAMED PATIENT, RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS PAID TO THE PRACTICE.**

Signature of Patient/ Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History** (Please circle)

Arthritis (unknown type) Cancer, if so type \_\_\_\_\_\_\_\_\_ Glaucoma Goiter/Thyroid Dysfunction

Osteoarthritis Seizures Lung Disease Kidney Disease

Gout Stroke Emphysema/ Asthma Rheumatic Fever

Childhood Arthritis High Blood Pressure Crohns/Ulcerative Colitis HIV

Lupus or “SLE” Heart Attack/ MI Stomach Ulcers Hepatitis

Rheumatoid Arthritis Congestive Heart Failure (CHF) GERD/ Acid Reflex Tuberculosis

Ankylosing Spondylitis A-fib/ Arrhythmia Anemia Anxiety/ Depression

Osteoporosis Cataracts Diabetes Psoriasis

Additional Medical Conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PREVIOUS OPERATIONS**:

|  |  |  |
| --- | --- | --- |
| TYPE | YEAR | REASON |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| 5. |  |  |
| 6. |  |  |

Any previous Fractures? No Yes Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other serious injuries? No Yes Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY**:

IF LIVING IF DECEASED

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | AGE | HEALTH | AGE AT DEATH | CAUSE |
| FATHER |  |  |  |  |
| MOTHER |  |  |  |  |

Number of siblings: \_\_\_\_\_\_\_\_\_\_ Number of living: \_\_\_\_\_\_\_\_\_ Number of Deceased: \_\_\_\_\_\_\_\_\_\_

Number of Children/Age: \_\_\_\_\_\_\_\_\_\_ Number of Living: \_\_\_\_\_\_\_\_\_\_ Number of Deceased: \_\_\_\_\_\_\_\_\_\_

**Family History of** (Please Circle):

Rheumatoid Arthritis Sjogrens Syndrome Osteoarthritis

Lupus “SLE” Thyroid Disease Gout

Anklosing Spondylitis Arthritis (unknown Type) Osteoporosis

SOCIAL HISTORY:

Do you drink caffeinated beverages? No Yes Cups/ Glasses per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? No Yes Past- How long ago? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? No Yes Number per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has anyone told you to cut down on your drinking? No Yes

Do you use drugs for reasons that are not medical? No Yes If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise regularly? No Yes Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount per week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours of sleep do you get a night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you get enough sleep at night? No Yes

Do you wake up feeling tired? No Yes

Do you have an advanced Directive? No Yes

**EDUCATION**: (circle highest level attended)

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School Disabled Retired

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of hours worked per week \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICATIONS:

Drug Allergies: Yes No To what: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRESENT MEDICAITONS: (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements)

|  |  |  |  |
| --- | --- | --- | --- |
| NAME OF DRUG | DOSE  (Include strength & # of pills) | HOW LONG HAVE YOU TAKEN THIS MEDICATION? | HAS THE MEDICATION HELPED?  (A lot/ Some/Not at all) |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| 5. |  |  |  |
| 6. |  |  |  |
| 7. |  |  |  |
| 8. |  |  |  |
| 9. |  |  |  |
| 10. |  |  |  |

SYSTEMS REVIEW

Last Mammogram\_\_\_\_\_\_\_\_\_\_\_\_ Last Pelvic Exam\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Colonoscopy\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Eye Exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Chest X-Ray\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Bone Density \_\_\_\_\_\_\_\_\_\_\_\_\_

Last TB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Shingles Vaccine \_\_\_\_\_\_\_\_\_\_\_\_\_ Pneumoccocal Vaccine \_\_\_\_\_\_\_\_\_



Please review the following list and check/circle any of these problems which have significantly affected you.

**GENERAL STOMACH SKIN**

Recent weight gain Nausea Rash

Amount \_\_\_\_\_\_ Vomiting of blood or coffee ground material Hives

Recent weight loss Stomach pain relieved by food/ milk Sun Sensitivity

Amount \_\_\_\_\_\_\_ Jaundice Tightness

Fatigue Constipation Nodules

Night Sweats Diarrhea Hair Loss

Fever Blood in Stool Color changes of hands/feet in the cold

**EYE** Black stool **NEUROLOGICAL SYSTEM**

Pain Heartburn Headaches

Redness **KIDNEY/URINE/BLADDER** Dizziness

Loss of vision Blood in urine Fainting/ passing out

Double/ blurred vision Genital Rash Weakness

Dryness Genital Ulcers Numbness/ Tingling/ Burning

Itching eyes **MUSCLES/JOINTS/BONES** Trouble with sleep

**EARS-NOSE-MOUTH-THROAT** Morning stiffness, Memory Loss

Nosebleeds If so, how long does it last Anxiety

Dryness in nose \_\_\_\_\_Minutes \_\_\_\_ Hours Depression

Bleeding Gums Joint Pain **BLOOD/ LYMPH NODES**

Sores in Mouth Muscle Weakness Swollen Glands

Dryness of Mouth Muscle Tenderness Tender Glands

Hoarseness Joint Swelling Anemia

Difficulty in swallowing List joints affected in the last 6 months Bleeding Tendency

Jaw Pain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Transfusion/ When \_\_\_\_\_\_

**HEART**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Blood Clots/ DVT/ PE

Pain in chest \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **FOR WOMEN ONLY:**

Irregular Heart Beat/ Palpitations \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age when periods began: \_\_\_\_\_

Heart Murmurs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last period: \_\_\_\_\_\_\_\_\_\_

**LUNGS** Bleeding after menopause? Y N

Shortness of breath Number of Pregnancies? \_\_\_\_\_\_

Swollen legs/feet Number of Miscarriages? \_\_\_\_\_\_

Cough / coughing blood

Wheezing

**DIRECTIONS TO 816 GREENBRIER CIRCLE, SUITE A CHESAPEAKE, VA 23320 PHONE (757) 461-3400**

FROM NORFOLK/ VIRGINIA BEACH: Take I-64 East to the Greenbrier Parkway North Exit. Turn right onto Woodlake Drive and continue straight (WAWA gas station on the left). Go straight across at the stop light, Woodlake Drive becomes Greenbrier Circle. As you continue on Greenbrier Circle there will be a Cedar Tree Inn and Extended Stay America Motel on the right. When you see the main entrance to the Wingate Hotel, turn left into Greenbrier Tech Center II. This is 816 Greenbrier Circle. The Center for Arthritis is located in Suite A at the end of the entrance road.

From Great Bridge/ North Carolina: Take I-64 West to the Greenbrier Parkway North Exit. Turn right onto Woodlake Drive and continue straight (WAWA gas station on the left. Go straight across at the stop light, Woodlake Drive becomes Greenbrier Circle. As you continue on Greenbrier Circle there will be a Cedar Tree Inn and Extended Stay America Motel on the right. When you see the main entrance to the Wingate Hotel, turn left into Greenbrier Tech Center II. This is 816 Greenbrier Circle. The Center for Arthritis is located in Suite A at the end of the entrance road.

From North Military Highway: Take Military Highway South to Old Greenbrier Road. Turn Left on Old Greenbrier and turn Left on to Woodlake Drive. Woodlake Drive becomes Greenbrier Circle. As you continue on Greenbrier Circle there will be a Cedar Tree Inn and Extended Stay America Motel on the right. When you see the main entrance to the Wingate Hotel, turn left into Greenbrier Tech Center II. This is 816 Greenbrier Circle. The Center for Arthritis is located in Suite A at the end of the entrance road.

From South Military Highway: Take Military Highway North to Greenbrier Parkway. Turn Right onto Greenbrier Parkway. Turn Left at Woodlake Drive and continue straight. (WAWA gas station on the left). Go straight across at the stop light, Woodlake Drive becomes Greenbrier Circle. As you continue on Greenbrier Circle there will be a Cedar Tree Inn and Extended Stay America Motel on the right. When you see the main entrance to the Wingate Hotel, turn left into Greenbrier Tech Center II. This is 816 Greenbrier Circle. The Center for Arthritis is located in Suite A at the end of the entrance road.

From Kempsville Road/ Volvo Parkway: Take Greenbrier Parkway North to Woodlake Drive. Turn Right onto Woodlake Drive and continue straight (WAWA gas station on the left). Go straight across at the stop light, Woodlake Drive becomes Greenbrier Circle. As you continue on Greenbrier Circle there will be a Cedar Tree Inn and Extended Stay America Motel on the right. When you see the main entrance to the Wingate Hotel, turn left into Greenbrier Tech Center II. This is 816 Greenbrier Circle. The Center for Arthritis is located in Suite A at the end of the entrance road.

**DIRECTIONS TO 1033 CHAMPIONS WAY, SUITE 100 SUFFOLK, VA 23435 PHONE (757) 483-2783**

Directions from I-664: Take exit 9A (James River Bridge exit). Merge onto US-17 North/Bridge Road. Turn right at the first light onto Harbour View Blvd. Go to the 3rd traffic light, turn left onto Champions Way. 1033 Champions Way will be on your left. If you have reached Konikoff Dentistry, you have gone too far.