Oregon Foot and Ankle Specialists

(Confidential Information – Important for our files and your health)

Name_____Date of Birth_____SS#_____

Address_____Phone #_____

City, State, Zip_____Cell #_____

**Email Address_____

Emergency Contact_____Phone #_____

Employer_____Phone #_____

Spouse_____DOB:_____SS #_____

Spouse's Employer_____Phone #_____

If Minor: Father's Name_____SS #_____
Father's Employer_____Phone #_____

Mother's Name_____SS#_____
Mother's Employer_____Phone #_____

Insurance Company_____
Please bring your insurance card and photo I.D. for us to copy.

How did you hear about this office?_____
Who may we thank for referring you?_____

Height_____Weight_____Shoe Size_____

Current Flu Vaccination: _____Yes _____No
Current Tetanus Vaccination: (Within last ten years) _____Yes _____No

What pharmacy do you use?_____Location:_____

State in your own words your medical reason(s) for coming to office.

_____

_____

**We do not share this information outside our office

Medical History

Family Physician_____

Has he/she requested you be seen in our office?_____

Former Podiatrist_____

1. Please list all medications that you use._____

_____

_____

_____

2. Any allergic reactions to medications?_____

_____

3. Do you smoke? _____Yes, if so, how much?_____ _____Former _____Never

4. Do you drink alcohol _____Yes, if so, how much?_____ _____No

5. Do you take any drugs? (Legal or Illegal) _____Yes, if so, how much?_____ _____No

FOR WOMEN ONLY: Are you pregnant?_____ if so, how many months?_____

6. **Family History:**

	Age if Living	Age at Death	Indicate any Serious Diseases	Cause of Death
Mother				
Father				
Siblings				

Indicate which of your relatives have had any of the following diseases:

Cancer_____ Diabetes_____
Heart Trouble_____ High Blood Pressure_____
Kidney Disease_____ Mental/Emotional Disease_____
Strokes_____ Arthritis_____

7. Please indicate by checking "yes" or "no" if you have had significant problems in the below areas. If yes, please comment in space indicated.

Nature of Problem

Yes	No		Yes	No	
		Recent Weight Loss			Liver, Gallbladder Disease
		Headaches			Stomach Trouble
		Trouble w/ Vision			Arthritis
		Trouble w/Hearing			Kidney Disease or Stones
		Allergies/Hayfever			Gout
		Asthma			Double Jointed
		Thyroid			Joint Pain or Stiffness
		Diabetes			Numbness in Feet or Legs
		Skin			Low Back Pain
		Anemia or Abnormal Bleeding			Depression
		Heart			Psychiatric
		Circulation			Fainting or Convulsions
		High Blood Pressure			Strokes
		Chest Pain			Pain in Other Areas
		Shortness of Breath(Cough, Wheezing)			Other Illnesses or Problems

Please explain any conditions in which you answered yes._____

_____

_____

8. Please give details of any surgeries or serious injuries.

_____

_____

9. Please inform us of any other important information._____

_____

10. Is there anything you wish to tell your physician privately? Yes☐ No☐

I consent to performance of any diagnostic procedures and/or the performance of non-surgical treatments that the doctor deems necessary.

Patient's/Parent's Signature:_____Date_____

CREDIT POLICY

We will be happy to bill your primary insurance company for you provided we have all of the necessary information, including insurance name, billing address, patient identification number, and group number. If your mailing address or insurance coverage changes, please notify our office as soon as possible.

Statements are sent monthly on or about the 25th of each month. **Payment in full is due upon receipt of statement,** unless prior payment arrangements have been made with our office.

We will allow 60 days for insurance processing. If your insurance company has not responded within that time period full payment is expected from you. You are responsible for the fees due the doctor regardless of the action of the insurance company. **Final responsibility of your account is yours.**

Accounts over 60 days old will be subject to a rebilling fee of $15.00 per month.
If we do not received payment from you, you will be subject to further collection procedures, or your account may be turned to a collection agency. You will be charged for any collection and/or attorney's fees.

Your signature on this page certifies that you have read and understand the policy as stated above. It authorizes the release of any medical information necessary to process your claims for services. It authorizes payment of medical benefits to the above named doctor/office for services on itemized statements and/or insurance claim forms.

Signed _____ Date _____

Patient's name _____

Subscriber's Name (If different from patient) _____

PATIENT RESPONSIBILITY DISCLAIMER

GOODS AND SERVICES

I understand and acknowledge that my insurance may not pay for all services or products provided to me during my care. If we, at Oregon Foot and Ankle Specialists, are aware of non-covered charges prior to providing them we will disclose this prior to proceeding with care.

There are however, instances when we cannot know ahead of time of services and or products dispensed that are not covered under your insurance. By signing, you understand that you may be financially responsible for part or all of those charges incurred in providing your care.

_____Patient signature

_____Date signed

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

_____ _____

Patient Name (please print) **Date**

_____

Parent or Authorized Representative (if applicable)

_____

Signature

As a patient of Oregon Foot Care Centers, would you like to elect to have others involved in your health care? Without your prior approval, we cannot discuss any medical information with family or friends. Please list the names of those you would like listed as being involved in your health care. This information can be changed or revoked with your permission at any time.

I give permission for information related to my current health status to be discussed with:

_____	_____	_____
Name	**Relationship**	**Telephone**
_____	_____	_____
Name	**Relationship**	**Telephone**
_____	_____	_____
Name	**Relationship**	**Telephone**