Northwest Footcare LLC

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How did you first hear about us?

*[ ] yellow pages [ ] friendly referral [ ] a Dr. referral, whom*___________________________________

Contact Information

Patient Name____ Date of Birth_________________ [ ] M [ ] F

Home address____

City____State_________________Zip__________________________

Mailing address____

Home Phone_____________________________________Work Phone____________________________________

Social Security #____Occupation_______________________________

Employers Name and Address____

Primary Insurance__________________________________Secondary Insurance____________________________

Person responsible for this bill (If different than above)

Name ____Date of Birth__________________________

Mailing address____

City____State________________Zip____________________________

Home Phone_____________________________________Work Phone______________________________________

Social Security #____Relationship________________________________

Agreement and Consent

I authorize the release of any medical information necessary to process insurance claims. I also authorize payment of medical benefits directly to Northwest Footcare LLC for professional services rendered. I understand that Northwest Footcare LLC will bill my insurance as a courtesy, but I am responsible for any balance not covered by my insurance.

I acknowledge that both the Financial Policy and Notice of Privacy Practices from Northwest Footcare LLC have been made accessible to me.

I give permission to the physicians at Northwest Footcare LLC to administer treatment and to perform such procedures as may be deemed necessary or advisable in the diagnosis and/or treatment of the foot and related conditions after I have consented. By Oregon law, I am entitled to know the procedure, alternatives and risks involved, with a detailed explanation if so desired.

I understand that undesirable outcomes MAY OCCUR with procedures and adverse side effects or reactions MAY OCCUR with medications. I will be responsible for following the doctor's instruction and that my non-compliance may result in a poor outcome and may be grounds for termination of the doctor/patient relationship. I will also be responsible for continuing any recommended follow up care and for any poor outcome which may result from the lack of doctor recommended follow up care.

____

Signature of Patient or Responsible Party   Date

Health History

Patient Name_______________________________Age_______Height_______Weight______Shoe size_____

Name of Primary Care Physician_________________________________ Date last seen___________________

What foot or ankle problems are you having? ____

____

When did this start? ____________________ Due to an injury? Yes No Workers Comp? Yes No

List any prior profession care your received for this issue

____

List all medications that you currently use <u>**or**</u> simply give your medication list to the secretary or nurse

____

List any allergies you have to medication____

List any surgeries you have had in the past with approximate dates.

____

Do you have a family history of?
[ ] Diabetes [ ] Cancer [ ] Heart Disease [ ] High Blood Pressure [ ] Stroke

Do you smoke? Y N packs per day? _______ Do you drink alcohol? Y N drinks per day? ________

Please check any condition that have or had

[ ] High Blood pressure
[ ] Heart Disease
[ ] High Cholesterol
[ ] Lung Problems
[ ] Stroke
[ ] Seizures

[ ] Diabetes
[ ] Hypo/Hyperthyroidism
[ ] Kidney Disease
[ ] Liver Disease
[ ] Stomach Problems
[ ] Cancer: type?_____________

[ ] Chronic Infections
[ ] Rheumatic Fever
[ ] Tuberculosis
[ ] Hepatitis
[ ] HIV/AIDS
[ ] Anxiety
[ ] Depression

[ ] Other condition(s) not listed___________________________________

Who should we contact in case of an emergency? ____
Phone
number__________________________________Relationship_______________________________________