

Northwest Footcare LLC

Bryan D. Wilhelm, DPM

Nat Chotechuang, DPM

Frank R. Cobarrubia, DPM

How did you first hear about us?

yellow pages friendly referral a Dr. referral, whom? _____

Contact Information

Patient Name _____ Date of Birth _____ M F

E-mail Address _____

Home Address _____

City _____ State _____ Zip _____

Mailing Address _____

Home Phone _____ Work Phone _____

Social Security # _____ Occupation _____

Employers Name & 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, and I agree to the terms therein.

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, and 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 instructions 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 professional care you received for this issue: _____

List all medications that you currently use: (or simply give your medication list to the receptionist)

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 **you** have or had:

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Chronic Infections
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hypo/Hyperthyroidism	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Stroke	<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Seizures	<input type="checkbox"/> Cancer: type? _____	<input type="checkbox"/> Anxiety
		<input type="checkbox"/> Depression

Other condition(s) not listed: _____

Who should we contact in case of an emergency? _____

Phone Number: _____ Relationship: _____