Northwest Podiatrists
The Foot & Ankle Clinics of Portland and SW Washington
www.nwpods.com

PATIENT INFORMATION

Name: (last) ______________________ (first) __________________ MI ___ DOB _________ Age _____ Sex

Street Address: ______________________________________ Marital Status: S M D W

______________________________________ Home Phone: ________________ H / W / C

Mailing Address: (if different from above) ______________________________________ Cell Phone: ________________ H / W / C

Email Address: ______________________________________ Language for Interpreter: ______________________

REFERRED BY: ________________________________ Primary Care Physician: ____________________________

Pharmacy: ________________________________ Pharmacy Phone: __________________________________

EMPLOYER

Retired: Y N Work Phone: _____________________

Name: ________________________ Address: ____

SPOUSE/PARENT/LEGAL GUARDIAN

Name: ____________________________________ Relationship to Patient: ____________________________

Address: ____________________________________ Phone: ____________________ DOB: _______________

INSURANCE INFORMATION

	Primary	Secondary
Insurance Company:	________________________________	____________________________________
Subscriber Name/DOB:	________________________________	____________________________________

EMERGENCY CONTACT

Name: ____________________________ Relationship: _____________________ Phone: ________________

AUTHORIZATION TO RELEASE INFORMATION * ASSIGNMENT OF BENEFITS * AGREEMENT CONTRACT

I hereby authorize Portland Foot & Ankle, LLC employees to release to my insurance company any information acquired in the course of my examination of treatment (if patient is minor, a parent or guardian must sign). I hereby agree to full responsibility for all expenses by me or on behalf of the above name patient and hereby assign to Portland Foot & Ankle, LLC any and all insurance benefits due to me to fulfill my financial obligations to the treating physician/provider. I understand my insurance coverage is a relationship between my insurance company and myself. I hereby agree to accept financial responsibility for payment for charges incurred. I understand that a $10.00 monthly fee will be applied to all balances over 30 days, complying with Oregon State Law. In the event of non-payment, I will bear the cost of collection and reasonable legal fees should this be required.

SIGNATURE: ____ **DATE:** ___________________________

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MEDICAL HISTORY

Name: ______________________________ DOB: ____________________

Shoe Size: ________ Height__________ Weight__________

Reason for today's visit: ____

____

Have you had any RECENT X-rays on your foot/ankle? Y N If yes, where: ____________________

Is this a work related injury? YES NO If yes, what date and time did it occur? ____________________

Please circle to indicate if you have any of the following conditions:

AIDS/HIV	Cancer, type	Fibromyalgia	Hypertension	Psychiatric Care
Alcoholism	Cardiac Arrhythmia	Glaucoma	Kidney Disease	Pulmonary Embolism
Anemia	Colitis	Gout	Leg or Foot Ulcers	Rheumatoid Arthritis
Anxiety Disorder	Congestive Heart Failure	Heart Attack (MI)	Lung Disease	Seizures/Epilepsy
Arthritis	Coronary Artery Disease	Heart Disease	Migraines	Sexually Transmitted Diseases
Artificial Joints	CRPS/RSD	Heart Problems	Osteoporosis	Stomach Ulcers
Asthma	Depression	Hemophilia	Pacemaker	Stroke
Back Problems	Diabetes	Hepatitis A, B, C	Peripheral Vascular Disease	Thyroid Disease
Bladder Infections	Dialysis	Hernia	Poor Circulation	Tuberculosis
Bleeding Disorder	Eczema	High Blood Pressure	Prostate Disease	Ulcers
Blood Clots	Esophageal Reflux/GERD	High Cholesterol	Psoriasis	Urinary Tract Infection

Other Medical Conditions: ____

MEDICATIONS (please list ALL prescription medication, over the counter and supplements):

____

____

____

Allergies to Medications: ____

_____ Current tobacco user _____ Former tobacco user _____ Never used tobacco

If current user: ________________

Cigarettes, how much _______ pack/day ____ years Chewing tobacco, how much ___ can/day ____ years

Do you drink alcohol: Y N If yes, how often ____________ / number of drinks_________

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SURGICAL HISTORY (please list all surgeries):

____

____

FAMILY HISTORY

Please list any MAJOR medical condition that your immediate family members have or have had:

Father ____ alive deceased

Mother ____ alive deceased

Sister ____ alive deceased

Brother ____ alive deceased

REVIEW OF SYSTEMS

Do you currently have or have you had in the past 6 months any of the following:

Constitutional

Chills	Y	N
Fever	Y	N
Unexplained weight gain	Y	N
Unexplained weight loss	Y	N

Head

Dizziness	Y	N

Respiratory

Asthma	Y	N
Shortness of Breath	Y	N

Cardiovascular

Chest Pain	Y	N
Cramps in legs/feet	Y	N
Extremity(s) Cool	Y	N

Endocrine

Excessive Thirst	Y	N
Fatigue	Y	N

Gastrointestinal

Heartburn	Y	N
Liver Disease	Y	N
Nausea	Y	N

Musculoskeletal

Back Pain	Y	N
Joint Pain	Y	N
Muscle Weakness	Y	N
Joint Stiffness	Y	N
Swelling of joints	Y	N

Psychiatric

Anxiety	Y	N
Depression	Y	N
Memory Loss	Y	N

Urinary

Excessive Urination	Y	N

Eye

Vision Problems/Blindness	Y	N

Skin

Dry/Scaly Skin	Y	N
Foot/Leg ulcers	Y	N
Itching	Y	N
Keloid scars	Y	N
Rash	Y	N
Ingrown nails	Y	N
Nail changes	Y	N

Neurological

Burning	Y	N
Numbness	Y	N
Tingling	Y	N
Unsteady gait	Y	N

Hematologic/Lymph

Anemia	Y	N
Bleeds easily	Y	N
Bruises easily	Y	N
Blood clots	Y	N

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information is dangerous to my health. It is my responsibility to inform the doctor's office of any changes to my medical status, including medications. I also authorize the healthcare staff to perform the necessary services that I may need.

Patient/Guardian Signature ________________________________ Date ____________________

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Before receiving care please understand the following:

1. It is the patient's responsibility to provide us with current and accurate insurance information, any time there is a change it is the patient's responsibility to notify us.
2. It is the patient's responsibility to know and understand their individual insurance plan, including deductible/coinsurance amounts, and what services will be billed to those amounts. Also, the patient shall seek and acquire the authorization from their Primary Care Provider, if this is a requirement of their insurance. Generally, we review this information with your insurance provider, however getting the approval before the visit occurs is always the patient's responsibility, and failure to acquire authorization will result in all charges being billed directly to the patient.

As a courtesy, we try to work with insurance companies to sort out billing issues, however failure to provide us with accurate information, or misunderstanding plan information will result in charges being billed out of pocket to the patient.

Assignment of Benefits
Your signature is necessary for us to process you insurance claims; and to ensure payment of benefits for services rendered on your behalf. I hereby authorize any payment of insurance, including Medicare, or other provider benefits for podiatry services by my provider on my behalf to be made directly to Foot and Ankle Clinics, my podiatry provider. I authorize any holder of medical information about me to release to the insurance carrier, or to the Health Care Financing Administration and its agents, any information needed to determine benefits payable for related services provided by my provider. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as the original.

Financial Responsibility
I understand that I am ultimately responsible for payment of expenses on my behalf or for those under my guardianship whether I have insurance coverage or not. It is my responsibility to determine if I have a valid referral for services provided, and this service is covered by my insurance. I also realize that I am responsible for any co-pay or any deductible/coinsurance which my insurance will not pay.

If a patient has multiple guardians, the person with the full time legal custody is ultimately responsible for the payment of our services, even if the insurance is provided by the other parent or guardian. In 50/50 custody situations, we will bill the parent where the child resides for school purposes. If the other parent has insurance responsibilities, we request that the responsible parent give legal authorization in writing, including legal signature, billing and insurance information. Unpaid balances over 60 days may be referred to an outside collection agency unless payment arrangements have been made with our office. A $30.00 charge will be made for all returned checks. NSF checks must be paid within seven (7) days of notification (by phone or mail) or be subject to immediate referral to collections.

If you have not insurance coverage, payment is required at the time of services, unless a payment arrangement has been made with our office.

Referrals and Prior Authorizations
It is my responsibility to know whether a prior authorization/pre-certification/referral is required for services to be covered by my insurance. It is my responsibility to obtain the appropriate referral forms from my Primary Care Provider is needed. In some cases, authorizations are required for X-ray, surgical services or in office procedures. If an authorization is needed and not properly obtained prior to services, I may be financially liable for the payment of services provided, and I hereby agree to be responsible for payment of these services.

I also realize that even with a valid authorization, some services may not be covered by my insurance carrier (such as routine foot care) and I agree to pay for these services in full if they are not covered by may plan.

I hereby accept that the above conditions are valid for this visit and any further visits, unless this document is revoked by me in writing.

Signature ____ Date___________________________