CENTRAL OREGON
FOOT & ANKLE
Podiatric Physicians & Surgeons

WELCOME TO OUR OFFICE

To aid in delivering the best possible health care, please complete in full

PATIENT PERSONAL INFORMATION

Name: First Middle Last			Soc. Sec. No.:	Family Doctor:
Mailing Address:			Date last seen by Family Doctor	Pharmacy
City	State	Zip	Email:	
Home Phone	Birth Date: / / Age:		Sex M / F	Marital Status *(Circle One)* Single Married Separated Divorced Widowed
Work:	Emergency Contact:		Employer/ School:	Occupation
Cell:				

Preferred language: English ☐ Other:_____
Race_____ ☐ Refuse to report

Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Refused to report

Is this an on-the-job injury? Yes ☐ No ☐

Date and time of injury_____

Workers Comp Insurance_____/ Claim#_____

INSURANCE

Please present your insurance forms, cards and identification to the receptionist

As a courtesy, this office will bill your primary insurance. A rebilling fee will be charged for all outstanding balances.

Primary Insurance Name:		Secondary Insurance Name:	
Insured Name on I.D. Card:	Insureds Birth Date: / /	Insured Name on I.D. Card:	Insureds Birth Date: / /
Soc. Sec. No. Member Policy ID		Soc. Sec. No. Member Policy ID	
Patient relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____		Patient relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____	

REFERRAL SOURCE

Please tell us how you chose us to provide your podiatric care

I was referred by _____, a ☐ Current or Past Patient ☐ Doctor ☐ Nurse or the _____ Hospital

I saw your name/ad in: ☐ Insurance Co. Provider List ☐ Yellow Pages ☐ Brochure/Literature ☐ Sign ☐ Online

☐ The _____ Newspaper or Magazine ☐ Dr.'s Lecture ☐ Other_____

ACCOUNT TERMS AND PAYMENTS

For Non-Insurance covered items and services

When your account has balances due over 60 days:
Your MONTHLY COST OF REBILLING/ACCOUNT MAINTENANCE CHARGE is $3.00

Today I will pay my bill by ☐ Cash ☐ Credit ☐ Check

In the Future, I can pay my bill by: ☐ Cash ☐ Credit ☐ Check

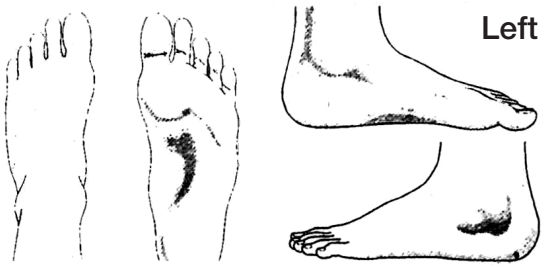
ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician. I am financially responsible for non-covered charges. I also authorize the physician to release any information required.

Patient or Authorized Person's Signature: _____ **Date:** _____

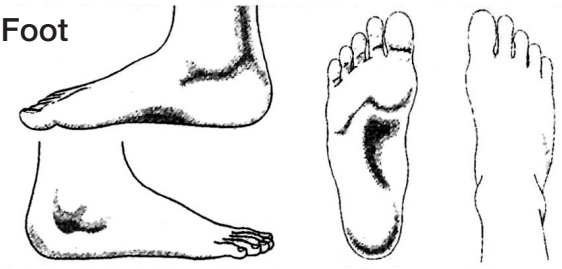
Name: _____

PATIENT'S CURRENT MEDICAL PROBLEMS

Left Foot



Right Foot



Please mark the location of your foot complaint above.

Please describe your foot complaint below

_____

_____

_____

Pain Level (1-10)_____

Does it limit your physical activities/work? ☐ Yes ☐ No

If yes, describe _____

Has it caused you to wear different shoes? ☐ Yes ☐ No

Have you tried pads/inserts? ☐ Yes ☐ No

Pain/Discomfort is
- ☐ Shooting Pain
- ☐ Throbbing Pain
- ☐ Sharp Pain
- ☐ Burning Pain
- ☐ Itching
- ☐ Aching Pain
- ☐ Tenderness
- ☐ Dull Pain
- ☐ Tingling
- ☐ Numbness

My pain/discomfort began (when)_____

_____

It occurs when _____

_____

Intensity is
- ☐ Mild
- ☐ Moderate
- ☐ Severe

It is getting
- ☐ Better
- ☐ No Change
- ☐ Worse

Describe any previous medical treatment(s) or home remedies:

_____

_____

PATIENT MEDICAL HISTORY:

HEIGHT_____ **WEIGHT**_____ **SHOE SIZE**_____ **AGE**_____

What percentage of your hours awake are you on your feet?

(Circle One) 20% 40% 60% 80% 100%

List any sports/regular exercise you are active in:

_____

_____

Do your feet hurt at night?	☐ Yes	☐ No
Do you have any difficulty in walking?	☐ Yes	☐ No
Do you get leg cramps?	☐ Yes	☐ No
Any pain in calves or buttocks when walking?	☐ Yes	☐ No
Do you have ingrown nails?	☐ Yes	☐ No
Do you have warts?	☐ Yes	☐ No
Do you have joint pain/stiffness?	☐ Yes	☐ No
Do you have fever/chills?	☐ Yes	☐ No
Do you have restless leg syndrome?	☐ Yes	☐ No
Do you take any blood thinners?	☐ Yes	☐ No
Do you have poor circulation?	☐ Yes	☐ No
Do you have feet or leg numbness?	☐ Yes	☐ No
Are you slow to heal after cuts?	☐ Yes	☐ No
Are you currently pregnant?	☐ Yes	☐ No
Any abnormal bruising or bleeding?	☐ Yes	☐ No

Do you have or have you ever been treated for:

☐ Diabetes 1 | 2	☐ Stomach Ulcer	☐ Cancer/type_____
☐ Epilepsy	☐ Blood Clots	☐ Psychiatric disorder
☐ Depression	☐ Heart Attack/date____	☐ Multiple Sclerosis
☐ Stroke	☐ Phlebitis	☐ High Blood Pressure
☐ Trauma	☐ Neuropathy	☐ Heart Disease
☐ Anemia	☐ Gout	☐ Liver Disease
☐ Asthma	☐ Lung Disease/type___	☐ Kidney Disease/dialysis?
☐ Raynauld's	☐ Arthritis	☐ Thyroid Disease
☐ Rheumatoid Arthritis	☐ Peripheral Vascular Disease	☐ Fibromyalgia

Have you had any other serious illness? Type _____

_____

_____

Please list hospitalizations in past 5 years/dates

_____

Are you currently taking insulin? ☐ Yes ☐ No

Are you currently taking any medications? ☐ Yes ☐ No

Please list medications or present your list to receptionist:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

List any allergies or reactions to medications

Medication Reaction

_____ _____

_____ _____

Surgical History _____ _____

_____ _____

_____ _____

Any history of anesthesia reaction? ☐ Yes ☐ No

List relationship to you of family members who have had:

Diabetes_____ Foot Problems_____

Arthritis_____ Heart Attack _____

Stroke_____ High Blood Pressure _____

Cancer _____ Birth Defects _____

Do you smoke now? ☐ Yes ☐ No Packs/day____ Years_____

Did you ever smoke? ☐ Yes ☐ No Packs/day____ Years_____

If you quit, what year did you quit?_____

Do you use marijuana?*(Circle One)* None Rarely Moderately Daily

Alcoholic beverages? None Rarely Moderately Daily

Recreational Drugs? None Rarely Moderately Daily