

Northwest Footcare, LLC

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How did you first hear about us?

Internet friendly referral Dr. referral, whom _____ Other

Contact Information

Patient Name _____ Date of Birth _____ M F

Preferred Name _____

Email _____

Home address _____

City _____ State _____ Zip _____

Mailing address _____

Primary 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 and I agree to the terms.

I give permission to the physicians at Northwest Footcare, LLC to administer treatment and to perform such procedures as maybe 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.

I understand that if I do not show up to my appointment, I will incur a \$25.00 fee.

Signature of Patient or Responsible Party

Date

Northwest Footcare, LLC
Comprehensive Health Review

Patient name: _____ Date of Birth: _____ Today's Date: _____
Age: _____ Height: _____ Weight: _____ Shoe size: _____ Gender: _____
Primary Care Provider name and clinic: _____

HISTORY OF PRESENT ILLNESS (WHAT BRINGS YOU IN?)

Describe your specific foot/ankle problem: _____

Which foot/ankle is involved? Left Right Both

Is this problem work-related (i.e., is it Workers' Comp)? Yes No

When did the problem begin? _____

Do you know what caused the problem? Yes No If yes, what was the cause? _____

What makes it better? _____ What makes it worse? _____

Is the problem painful? Yes No

If painful, how severe is it? (none) 0 1 2 3 4 5 6 7 8 9 10 (extreme)

What treatments have you tried, if any? _____

PAST MEDICAL HISTORY

- | | | |
|---|--|--|
| <input type="checkbox"/> Alzheimer's/dementia | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Thyroid (<input type="checkbox"/> low <input type="checkbox"/> high) |
| <input type="checkbox"/> Autoimmune disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Other problems not listed:
_____ |
| <input type="checkbox"/> Blood clot/DVT | <input type="checkbox"/> High cholesterol | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV/AIDS | _____ |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Hypertension | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis | _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Peripheral arterial disease | |

PAST SURGERIES

Please list: _____

FAMILY HISTORY

Cancer Diabetes Heart disease Foot problems Other: _____

ALLERGIES and Reaction

Please list: _____

Northwest Footcare, LLC
Comprehensive Health Review

MEDICATIONS (or provide list)

_____	_____
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY

I use Tobacco: Yes No
I drink Alcohol: Yes No How much? _____
I use recreational and/or illicit drugs: Yes No
Occupation: _____ Mostly seated Mostly standing Lots of walking
Activities/Sports: _____

REVIEW OF SYSTEMS (please check box if you currently have any of the following)

GENERAL

- Fever/Chills
- Nausea/Vomiting

EYES/EARS/NOSE//THROAT

- Hearing loss
- Sore Throat

CARDIOVASCULAR

- Chest pain
- Leg pain when walking
- Poor circulation
- Swelling in legs and feet

RESPIRATORY

- Shortness of breath
- Chronic cough
- Difficulty breathing

GASTROINTESTINAL

- Digestive disorder

- Blood in stool

GENITOURINARY

- Frequent urination
- Blood in urine
- Kidney stones

INTEGUMENTARY

- Rash
- Dry, scaly skin
- Athlete's foot

MUSCULOSKELETAL

- Back pain
- Joint stiffness
- Joint pain

ENDOCRINE

- Hormone imbalance
- Too hot/Too cold
- Excessive thirst

- Excessive urination

NEUROLOGICAL

- Numbness/Tingling
- Dizziness
- Tremors
- Restless leg

PSYCHIATRIC

- Insomnia
- Confusion
- Memory loss

HEMATOLOGIC

- Bruise easily
- Bleed easily
- Use of blood thinners

IMMUNOLOGIC

- Weakened immune system
- Swollen lymph nodes

The information I have provided is true and accurate to the best of my knowledge. I recognize that the information I have provided will help me receive better care.

X _____
Patient/Guardian Signature Date