PODIATRIC REGISTRATION AND HISTORY

PATIENT INFORMATION

Date ______________________

Patient Name ______________________________

Address ______________________________

____

City State Zip

Sex: ☐ M ☐ F Age _____ Birth Date ___________

Patient SS# ______________________________

Occupation/Employer ______________________________

Employer ______________________________

Work Address ______________________________

☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

Spouse's Name ______________________________

Birth Date ______________ SS# ______________

Occupation/Employer ______________________________

Did another physician refer you to our office?

☐ Yes ☐ No, Their name ______________________

Whom referred you? ______________________________

Who is your Primary Care Dr:

PHONE NUMBERS

Home _______________ Cell _______________

Work______________________________

Best time & place to reach you ______________

IN CASE OF EMERGENCY, CONTACT

Name _______________ Relationship ___________

Home phone ___________ Work ___________

INSURANCE

Who is responsible for this account? ______________________

Relationship to patient ______________________________

Insurance Co. ______________________________

Policy # ____________________ Group # __________________

Supplemental Insurance Company ______________________

Subscriber Name ______________________________

Birth Date ____________________ SS# __________________

Relationship to patient ______________________________

Policy Dates From _______________ to ___________________

Policy # ____________________Group # __________________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ______________________ and assign directly to Dr. Steve Tillett all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

______________________________ ____________________

Responsible Party Signature Date

______________________________ ____________________

Relationship Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Steve Tillett for any services furnished me by that physician. I authorize any holder of medical information about me, to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

______________________________ ____________________

Beneficiary Signature Date

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated?

____

____

____

____

____

Have you ever been seen by a Foot Specialist before? ☐ Yes ☐ No

If yes, please list:

Name ______________________________

Last visit ______________________________

Shoe Size ____________

Weight ____________

Athletic activities in which you participate (please list and indicate frequency)

____

____

____

____

____

Is there a personal or family history of Diabetes? ☐ Yes ☐ No

Please indicate which foot problems you now have or have had in the past:

Problem	Yes	No
Heel pain	☐ Yes	☐ No
Ingrown Toenails	☐ Yes	☐ No
Ankle Pain	☐ Yes	☐ No
Athlete's Foot	☐ Yes	☐ No
Bunions	☐ Yes	☐ No
Corns and Calluses	☐ Yes	☐ No
Numbness in Feet or Legs	☐ Yes	☐ No
Flat Feet	☐ Yes	☐ No
Foot or Leg Cramps	☐ Yes	☐ No
Plantar Warts	☐ Yes	☐ No
Swelling in Ankles or Feet	☐ Yes	☐ No

PODIATRIC REGISTRATION AND HISTORY

MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Condition	Yes	No
Anxiety	☐ Yes	☐ No
AIDS/HIV	☐ Yes	☐ No
Alcohol abuse History	☐ Yes	☐ No
Drug Abuse History	☐ Yes	☐ No
Angina (chest pain)	☐ Yes	☐ No
Artificial Joints (which:________)	☐ Yes	☐ No
Artificial Heart valves	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No
Bleeding Problems	☐ Yes	☐ No
→ Explain:		
Blood Clots (DVT's)	☐ Yes	☐ No
Phlebitis	☐ Yes	☐ No
Burning in Feet / Neuropathy	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
→ What kind:		
Chronic Diarrhea	☐ Yes	☐ No
Circulation Problems	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Eye Problems	☐ Yes	☐ No
Foot or Leg Cramps	☐ Yes	☐ No
Foot Ulcers	☐ Yes	☐ No
Gout	☐ Yes	☐ No
Heart Trouble (Murmur)	☐ Yes	☐ No
Heart Attack (when:__________)	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Kidney Problems	☐ Yes	☐ No
Liver Disease (Hepatitis)	☐ Yes	☐ No
Psychiatric Care	☐ Yes	☐ No
Rheumatic Arthritis	☐ Yes	☐ No
Special Diet (kind:___________)	☐ Yes	☐ No
Stroke or Heart Attack	☐ Yes	☐ No
Swelling in Ankles/Feet	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Stomach Ulcers	☐ Yes	☐ No
Varicose Veins	☐ Yes	☐ No
Venereal Disease	☐ Yes	☐ No

☐ I have not had Surgery before

Please List Surgeries you have had (include approximate year):

____

____

____

☐ *I have NOT had complications with Anesthesia from previous surgeries*

Please list hospitalizations other than for surgeries listed above: ____

____

Family physician _______________________________________Date of last visit ____________________

Are you now or have you been, under any other doctor's care for any reason over the past two years? ☐ Yes ☐ No

If yes, please explain ____

____

Is there any chance that you could be pregnant now? ☐ Yes ☐ No

Tobacco Use: ☐ Never ☐ Cigarettes Quit Date __________ ***Current Smoker***: Packs/day?_______ # of years? __________

Other Tobacco: ☐ Pipe ☐ Cigar ☐ Chew ***Alcohol use***: ☐ No ☐ Yes → # of Drinks/week of: beer ___ wine ___ hard alcohol ___

MEDICATIONS

Indicate prescriptions, over-the-counter medications and vitamins ________

____

____

____

____

Pharmacy Name(s) ____

Pharmacy Phone(s) ____

Do you take oral contraceptives? ☐ Yes ☐ No

ALLERGIES

☐ **I do NOT have any drug allergies**

☐ Penicillin
☐ Iodine
☐ Seafood
☐ Local Anesthetic (Novocain)
☐ Codeine
☐ Aspirin
☐ Demerol
☐ Adhesive Tape
☐ Sulfa

☐ Other ___________________________

____

____

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet, or medical conditions affecting my feet.

Patient (or guardian) signature ____ Date ____________________

Steven G. Tillett, D.P.M.

Diplomat, College of Foot and Ankle Surgeons

6327 SW Capitol Hwy, Suite B
Portland, Oregon 97239

511 SW 10th Ave, Suite 811
Portland Oregon, 97205-2709

Notice of Privacy Practices Acknowledgment and Consent

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be use to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers whomay be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

____ ________________________
Patient Name (please print) Date

____
Patient or Authorized Representative (if applicable)

____
Signature

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: