CASCADE FOOT & ANKLE CLINIC

MARK K. WILLIAMS, D.P.M., F.A.C.F.A.S. NICOLE S. CARNEY, D.P.M., MOLINA K. KOCHHAR, D.P.M.
LOREN B. STONE, JR., D.P.M
Physicians and Surgeons of the Foot & Ankle

PATIENT INFORMATION

PATIENT LEGAL NAME: (FIRST/M.I./LAST)					DATE:
ADDRESS:					DATE OF BIRTH:
CITY:		STATE:			ZIP:
HOME PHONE: ( )		WORK PHONE: ( )			SOCIAL SECURITY #:
SEX: MALE ☐ FEMALE ☐	AGE:	SHOE SIZE:	HEIGHT:	WEIGHT:	MARTIAL STATUS: S ☐ M ☐ W ☐ D ☐
PATIENT EMPLOYER:				OCCUPATION:	
EMERGENCY CONTACT PERSON:		RELATIONSHIP TO PATIENT:			PHONE: ( )

MINOR INFORMATION

PARENT/LEGAL GUARDIAN NAME: (FIRST/M.I./LAST)	RELATIONSHIP TO PATIENT:

INSURANCE INFORMATION

PRIMARY INSURANCE:	GROUP #:	SUBSCRIBER #:
PRIMARY SUBSCRIBER NAME: (FIRST/M.I./LAST)	SUBSCRIBER BIRTHDATE:	RELATIONSHIP TO PATIENT:
SECONDARY INSURANCE:	GROUP #:	SUBSCRIBER #:
SECONDARY SUBSCRIBER NAME: (FIRST/M.I./LAST)	SUBSCRIBER BIRTHDATE:	RELATIONSHIP TO PATIENT:

PHYSICIAN INFORMATION

PRIMARY CARE PHYSICIAN:	
ADDRESS:	REFERRED BY PRIMARY CARE PHYSICIAN: YES / NO

ASSIGNMENT OF BENEFIT: I hereby assign all medical and/or surgical benefits to which I am entitled, to the physician providing treatment, Mark K. Williams, D.P.M., FACFAS, Nicole S. Carney, D.P.M., or Molina K. Kochhar, D.P.M., Loren B. Stone, Jr., D.P.M. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that if I have insurance, I am financially responsible for charges whether or not they are covered by said insurance.

PATIENT LEGAL SIGNATURE:	**TODAY'S DATE:**

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PLEASE CHECK ALL THAT APPLY

MEDICAL HISTORY:

☐ Diabetes ☐ High Blood Pressure ☐ Arthritis ☐ Ulcers ☐ Heart Disease
☐ Emphysema/COPD ☐ Congestive Heart Failure ☐ Anesthesia Reactions
☐ Cancer ☐ Hepatitis ☐ Fibromyalgia ☐ Gout ☐ Hypothyroidism
☐ Other____

____

SURGICAL HISTORY:

☐ Tonsillectomy ☐ Appendectomy ☐ Hernia Repair ☐ Hysterectomy
☐ Gall Bladder Removal ☐ Bladder Suspension ☐ Bunion Repair ☐ Cardiac Bypass
☐ Other____

____

FAMILY HISTORY:

☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ Arthritis ☐ Cancer (type) ______________
☐ OTHER____

____

SOCIAL HISTORY:

☐ Drink Coffee/Tea (cups/day) ____
☐ Alcohol (amount/day/week) ____
☐ Smoking (amount/day) ____
☐ Number of Years You Have Smoked____

CURRENT MEDICATIONS: ____

____

____

DRUG ALLERGIES/REACTIONS: ____

____

____

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GENERAL HEALTH (CHECK ALL THAT APPLY)

Current Foot/Ankle Problems	Duration of Problem	Prior Treatments	Describe Problem: (pain, swelling, redness, drainage etc)
☐ Ingrown Nails			
☐ Bunion			
☐ Plantar Fasciitis			
☐ Corns/Calluses			
☐ Hammertoe			
☐ Neuroma			
☐ Warts			
☐ Ankle Pain			
☐ Fracture			
☐ Other/Unknown			

HAVE YOU EVER BEEN TREATED BY A PODIATRIST?
☐ Yes ☐ No Date of Last Visit: ___________________________

FEMALES ARE YOU:
☐ Pregnant ☐ Nursing ☐ Birth Control Pills ☐ None
☐ Other Relevant Information: ____

CONSTITUTIONAL - RECENT:
☐ Fever ☐ Chills ☐ Dizziness

EYES:
☐ Glaucoma ☐ Cataracts

EARS, NOSE, THROAT:
☐ Ringing Of Ears ☐ Hearing Impairment ☐ Difficulty Swallowing

CARDIOVASCULAR:
☐ Heart Attack ☐ Stroke ☐ Blood Clot ☐ Clotting Disorder
☐ Murmur ☐ High Blood Pressure ☐ Chest Pain

RESPIRATORY:
☐ Asthma ☐ Shortness of Breath ☐ Sleep Apnea ☐ Snoring

GASTROINTESTINAL:
☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Stomach Ulcers ☐ Blood In Stools ☐ Colitis

GENITO/URINARY:
☐ Painful or Frequent Urination ☐ Impotence ☐ Blood in Urine
☐ Sexually Transmitted Disease____

MUSCULOSKELETAL-PAINFUL:
☐ Back Muscle Joint or Bone ☐ Muscle Weakness ☐ Joint Pain

SKIN:
☐ Eczema ☐ Psoriasis ☐ Athlete's Foot ☐ Dermatitis ☐ Rash ☐ Ulcer

NEUROLOGICAL:
☐ Peripheral Neuropathy ☐ Numbness ☐ Burning ☐ Stabbing Pains
☐ Seizures ☐ Tremors

PSYCHIATRIC:
☐ Anxiety ☐ Depression ☐ Drug/Alcohol Addiction ☐ Paranoia
☐ Other____

ENDOCRINE:
☐ Diabetes ☐ Fatigue ☐ Unexplained Weight Loss

HEMATOLOGIC/LYMPHATIC:
☐ Bloating ☐ Swelling ☐ Edema ☐ Bleeding

ALLERGIC/IMMUNOLOGY:
☐ Allergies (seasonal, environmental, latex, other) ________________________________

____

☐ Gout ☐ Rheumatoid Arthritis ☐ Lupus

☐ Other____

PAYMENT AGREEMENT

I understand that I am required to present at the time of my appointment, current insurance coverage and billing information. I also understand that it is my personal responsibility to know what services my insurance covers and the amount of my co-pay.

In the event that I do not present my medical insurance card and/or current billing information, or if I do not have current medical insurance, I understand that I am financially responsible to Cascade Foot & Ankle Clinic for the full amount of services rendered at this visit and future visits.

I, the undersigned, certify that I or my dependent have insurance coverage with ____________________ and assign directly to Cascade Foot & Ankle Clinic 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 payment benefits. I authorize the use of this signature on all insurance submissions. In the event legal action should become necessary to collect any unpaid balance due for medical services rendered to me or my dependents, I/we agree to pay reasonable attorney fees or other such costs as the Court determines proper. I agree that the venue for any legal action shall be in Thurston County.

By my signature, I agree to be financially responsible for any services provided on my behalf or my dependent's behalf that are not covered by insurance.

Date: __________________

Patient Name: _____________________________Signature:_________________________________
Please Print (If over 18 years of age)

Parent or
Guardian: ________________________________Signature:___________________________________
Please Print

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NOTICE OF PRIVACY PRACTICES-ACKNOWLEDGEMENT

We keep a record of the health care services we provide for you. With valid identification, you may ask to see that record and request that we provide a copy for you. There will be a minimum charge if copies of your record are required. We will not disclose your record to others unless you direct us to do so, or unless the law compels us to do so. You may see your record or get more information about it by contacting our office staff.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

Please check how you would like us to contact you regarding your health care information from this office.

***It is okay to leave a detailed message on my personal answering machine. This message may

include specific health information. i.e. lab results, medications, appointments.

Yes _____ No _____

***It is okay to call me at work regarding healthcare information.

Yes _____ No _____

***It is okay to leave a message with person specified regarding my healthcare information.

Name: ____ Relationship: _________________________

By my signature below, I acknowledge receipt of the Notice of Privacy Practices for this office.

____

Patient or legally authorized individual signature Date

____

Printed name if signed on behalf of the patient Relationship to patient
(Parent, guardian, representative)

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