Evan C. Merrill, DPM, FACFAS

Devin G. Dimond, DPM, AACFAS

Welcome!

Dear

Thank you for choosing Southern Oregon Foot & Ankle for your podiatric care! Please fill out the enclosed forms and bring them with you to your appointment.

Your Appointment:

Day:_____Date:_____ Time:_____

☐ Dr. Merrill ☐ Dr. Dimond

Please arrive 15 minutes prior to your appointment time.

The following items are needed along with the completed forms:

1. **Medications:** Current list – refer to your prescription bottles for correct spelling and dosage
2. **Insurance Cards**
3. **X-Rays:** If applicable
4. **Worker's Comp Claims** or **Motor Vehicle Accidents**: If applicable.

As a new patient, there will be a new patient office visit charge and possible additional charges such as x-rays and/or procedures, which you and your doctor will determine at the time of your visit. **We collect any co-pays and/or a deposit toward any unmet yearly deductible at the initial appointment.** For self-pay patients, we offer a 10% discount if paid in full on the Date of Service.

We look forward to serving you!

Your friends at Southern Oregon Foot & Ankle

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Patient Information

(Please Print Clearly)

Name (First)_____ (Middle)_____ (Last)_____

SSN_____ Date of Birth_____ Gender_____ AKA_____

Street Address_____ City_____ State_____ Zip Code_____

Home Phone_____ Work Phone_____ Cell Phone_____ Fax_____

Preferred/Message Phone: ☐ Home ☐ Work ☐ Cell Email Address_____

Mailing Address (if different from Street Address)_____

Please complete each section:

1. Race: ☐ African American ☐ Caucasian ☐ Eastern Indian ☐ Hispanic ☐ Asian ☐ Decline ☐ Other_____

2. Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Decline **3. Language**: ☐ English ☐ Spanish ☐ Other_____

Marital Status_____ Employer_____

Primary Physician_____ Preferred Pharmacy_____

How Did You Hear About Us?_____

PERSON RESPONSIBLE FOR BILL (if other than the patient of if the patient is a minor) ☐ Check here if same as above

Name (First)_____ (Middle)_____ (Last)_____

SSN_____ Date of Birth_____ Gender_____ AKA_____

Street Address_____ City_____ State_____ Zip Code_____

Home Phone_____ Work Phone_____ Cell Phone_____

MEDICAL INSURANCE INFORMATION ☐ Medicare ☐ Oregon Health Plan

Primary Insurance_____ Policyholder Name_____ Relationship to Patient_____

Policyholder Birth Date_____ Insured ID #_____ Group #_____

Address of Policyholder (if not self)_____

Secondary Insurance_____ Policyholder Name_____ Relationship to Patient_____

Policyholder Birth Date_____ Insured ID #_____ Group #_____

Address of Policyholder (if not self)_____

Is this visit due to: ☐ A work-related accident? ☐ An automobile accident? Date of Injury_____

Claim #:_____ Insurance Company_____

EMERGENCY INFORMATION

Emergency Contact Name_____ Relationship_____ Phone_____

Address_____

Consent and Authorizations:

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

If I have (or my dependent has) insurance coverage, I assign directly to Southern Oregon Foot & Ankle all insurance benefits or Medicare benefits for the 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.

Signature_____ **Date**_____

*(Office Use Only) DOB*_____ *Chart No.*_____

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Patient Medical History

(Please Print Clearly)

Name (First)_____ (Middle)_____ (Last)_____

- Current Weight_____ Height_____ Shoe Size_____

List all allergies to medications_____

- Other Allergies: ☐ Tape ☐ Betadine (Iodine) ☐ Latex – What is your reaction?_____

List all current medications with dosage_____

REASON FOR THIS VISIT

Describe your foot problem_____ ☐ Right ☐ Left

- How long has it been bothering you? Days_____ Weeks_____ Months_____ Years_____
- Have you had X-rays taken for this problem? ☐ No ☐ Yes If yes, where?_____

Does today's visit relate to an accident? ☐ No ☐ Yes If yes, is it related to: ☐ Work ☐ Auto ☐ Other_____

- Date of Injury_____

List any past surgical procedures on your feet or ankles_____

Any additional foot issues?_____

Your family physician's name_____ Did he/she refer you to this office? ☐ No ☐ Yes

MEDICAL HISTORY

Do you have Diabetes? ☐ No ☐ Type 1 ☐ Type 2 ☐ Gestational For how long?_____

Check any previous or current problems:

☐ Anemia	☐ Frequent Infections	☐ Ingrown Nails	☐ Plantar Fasciitis
☐ Arthritis: ☐ *Rheumatoid* ☐ *Osteo*	☐ Ganglions	☐ Intestines	☐ Rheumatic Fever
☐ Asthma (*Onset:*_____)	☐ Gout	☐ Kidneys	☐ Skin
☐ Bleeding Disorder	☐ Hammer Toes	☐ Lung Condition	☐ Stomach Ulcers
☐ Bunions	☐ Healing Difficulties	☐ Neurological Disorder	☐ Stroke
☐ Circulation	☐ Heart	☐ Neuromas	☐ Thyroid
☐ Corns & Calluses	☐ Hepatitis: ☐ *A* ☐ *B* ☐ *C*	☐ Peripheral Neuropathy	☐ Tuberculosis
☐ Flat Feet	☐ High Blood Pressure	☐ Peripheral Vascular Disease	☐ Warts
☐ Foot Ulcer	☐ High Cholesterol	☐ Other_____	

Additional details on any of the above checked problems:_____

Other medical conditions_____

For which of these conditions are you under a physician's care?_____

Approximate date you last saw your doctor_____

May we contact your physician about your health? ☐ No ☐ Yes_____

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Patient Medical History
(Cont'd)

Patient Name_____

SURGICAL HISTORY

Do you have any artificial joints? ☐ No ☐ Yes Where?_____

Do you have a Heart Valve Implant? ☐ No ☐ Yes

List any other major surgeries_____

_____

_____

SOCIAL HISTORY

Tobacco Use:

☐ Current Smoker Number of packs per day_____ for_____ months, or_____ years.

☐ Ex-Smoker

☐ Never Smoked

☐ Current Chewing Tobacco User

☐ Ex-Chewing Tobacco User

Do you drink alcohol or beer? ☐ No ☐ Yes Frequency_____

Do you use medical marijuana? ☐ No ☐ Yes

Do you use recreational drugs? ☐ No ☐ Yes If yes, what and how often?_____

FAMILY HISTORY

Father: ☐ Living ☐ Deceased Cause_____

Mother: ☐ Living ☐ Deceased Cause_____

Brother: ☐ Living ☐ Deceased Cause_____

Sister: ☐ Living ☐ Deceased Cause_____

Check any of the problems a blood relative of yours has had or has:

☐ Arthritis	☐ Blood Clots	☐ Diabetes	☐ Heart Disease
☐ Bleeding Disorder	☐ Cancer	☐ Flat Feet	☐ Neurological Disorder
☐ Bunions	☐ Circulation problems in legs or feet	☐ Hammer Toes	☐ Stroke

Signature_____ **Date**_____

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Patient Financial Policies

Welcome to Southern Oregon Foot & Ankle.

This form should help you clearly understand our financial policy. If you have any questions regarding your responsibility, please do not hesitate to ask.

- If you do not have medical insurance or if the deductible of your insurance policy has not been met, full payment is expected on the day of service. Payment options are cash, check, VISA, MasterCard, and Discover Card.
- Co-pays must be paid at each visit per your insurance contract. **NOTE:** WHEN CO-PAYS MUST BE BILLED, THERE IS AN ADDITIONAL $10 BILLING FEE.
- If you have insurance but do not provide the information at the time of visit, payment in full is expected. We will give you 48 hours to provide the insurance information before processing your payment.
- If payment has not been made for 60 days, once the balance becomes your responsibility, the account may be assessed a finance charge of 1.5% per month.
- For surgical procedures you will be asked to pay for a portion of the cost prior to the surgery. The labs, hospital, and anesthesiologist charges are billed separately, and you will receive a statement from those providers.
- For worker's compensation cases or motor vehicle accidents, we will bill the appropriate insurance. If your claim is denied you will be responsible for payment in full.
- If you are being treated as part of a personal injury lawsuit or claim, payment of the bill remains your responsibility. We cannot bill your attorney for charges incurred due to your personal injury.
- By signing this form, you are giving Southern Oregon Foot & Ankle authority to release any information required to complete your insurance claim. The authorization will be effective until you choose to revoke in writing.

By signing this form, you understand this policy and are bound by it.

Print Name of Patient	Patient Signature	Date of Birth
Print Name of Responsible Party (if different than patient)	Signature of Responsible Party	Date

Co-Payment: The amount determined by your insurance policy that you must pay at each office visit at the time of service
Co-Insurance: An amount (which is usually a percentage) of the fee that you are required to pay as determined by your insurance.
Deductible: The amount you must pay out of your pocket before your insurance with pay for services.