Evan C. Merrill, DPM, FACFAS
Adam J. Gerber, DPM, AACFAS
1904 E. Barnett Road
Medford, OR 97504

New Patient
W E L C O M E

Dear New Patient:

Thank you for choosing Southern Oregon Foot & Ankle, for your podiatric care! Please read and complete the Patient Information, Medical History, Patient Financial Policy, and Patient Privacy registration forms and fill them out as **accurately as possible**.

Please arrive at least 15 minutes ahead of your appointment to allow time for us to finalize the registration process. Your appointment is scheduled for:

The following items are needed along with the completed forms:

1. **Medications:** Make sure to list on the Medical History Form (or a separate sheet of paper) all of the medications you are currently taking. Please refer to your prescription bottles for correct spelling and dosage. Also, include any over-the-counter medications.
2. **Insurance Cards:** We will scan your cards so that we can more accurately bill your insurance.
3. **X-Rays:** Bring a copy of any prior x-rays taken of your feet within the last 12 months.
4. **Worker's Comp Claims or Motor Vehicle Accidents:** If your visit is related to a worker's comp claim or a motor vehicle accident, please come prepared with your date of injury, claim number, and any other pertinent information for billing your claim.

Please note that you are responsible for paying any copays at the time of visit. We also require a deposit toward your services if you have not met your deductible for the year.

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 the doctor will determine at the time of your visit.

Directions: We are located at **1904 E. Barnett Road, Medford, Oregon**. From Interstate 5, take the South Medford Exit (#27). Follow the signs to Barnett Road. At the light, take a right and head east on Barnett Road. After you cross over Ellendale Road, we are the second driveway on the right. (You will be turning into the drive right before our green building.)

If you are coming from the east side of town down Barnett Road, we will be on the left hand side of the road. As soon as you pass our building you will turn left into the driveway.

We look forward to meeting and serving you!

Dr. Evan Merrill   Dr. Adam Gerber & Staff

Patient Information

(VERIFY INFORMATION & PLEASE PRINT)

Southern Oregon Foot & Ankle, LLC
Evan C. Merrill, DPM, FACFAS
Adam J. Gerber, DPM, AACFAS

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) ____

Complete each line:

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 _________________________ Level of Education ________________________________ Student: ☐Full time ☐Part time

Employment ____ Primary Doctor ____

Preferred Pharmacy ____ Referral Source ____

PERSON RESPONSIBLE FOR BILL (if other than the patient or if the patient is a minor)

Check here if same as above ☐

Name (first) _______________________________ (middle) ______________________________ (last) ______________________________

SSN ____________________ Date of birth __________________ Gender _______ Relationship to patient _______________________

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 policy holder if not self ____

Secondary Insurance _______________________ Policyholder name ________________________ Relationship to patient ______________

Policyholder birth date ____________________ Insured ID# ___________________________ Group # ______________________________

Address of policy holder 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, LLC, 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 _______________________________

Patient Medical History

(PLEASE PRINT)

Southern Oregon Foot & Ankle, LLC
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Name (first) ______________________________ (middle) ______________________________ (last) ________________________________

Current weight _______________________ Height ____________________ Shoe size _______

List all allergies to medications ____

Other allergies: ☐ LATEX – What is your reaction?_______________________________________ ☐ Tape ☐ Betadine (iodine)

List all current medications with dosage____

____

____

Reason for this Visit

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

Describe your foot problem ____ ☐ Right ☐ Left

How long has it been bothering you? Days ________ Weeks ________ Months ________ Years ________

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

Date of injury _________________________

Indicate any past problems of your feet and ankles ____

☐ Bunions	☐ Flat Feet	☐ Gout	☐ Neuromas	☐ Plantar Fasciitis
☐ Circulation	☐ Foot Ulcer	☐ Hammertoes	☐ Peripheral Neuropathy	☐ Warts
☐ Corns & Calluses	☐ Ganglions	☐ Ingrown Nails	☐ Peripheral Vascular Disease	☐ Other _____________

List any past surgical procedures on your feet or ankles ____

____

Medical History

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

Check any of the problems you have had or have:

☐ Anemia	☐ Healing Difficulties	☐ Intestines	☐ Skin
☐ Arthritis (osteo)	☐ Heart	☐ Kidneys	☐ Stomach Ulcers
☐ Arthritis (rheumatoid)	☐ Hepatitis ☐ A ☐ B ☐ C	☐ Lung Condition	☐ Stroke
☐ Asthma (onset _________)	☐ High Blood Pressure	☐ Neurological Disorder	☐ Thyroid
☐ Frequent Infections	☐ High Cholesterol	☐ Rheumatic Fever	☐ Tuberculosis

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 ____

Patient Medical History

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 user chewing tobacco

☐ 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 family (blood relative) history of:

☐ Arthritis ☐ Circulation problems in legs or feet ☐ Heart Disease

☐ Bleeding Disorder ☐ Flat Feet ☐ Neurological Disorder

☐ Bunions ☐ Hammertoes ☐ Stroke

☐ Blood Clots

Signature ____ Date ______________________________

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Patient Financial Policies

Welcome to Southern Oregon Foot and 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, American Express, and Discover Card. We also offer Care Credit.
- Co-pays must be paid at each visit per your insurance contract and as required by law.
- It is your responsibility to know your insurance plan and what is covered and what is not.
- 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 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 and Ankle, LLC authority to release any information required to complete your insurance claim. The authorization will be effective until you choose to revoke it in writing.

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

______________________________	______________________________	______________________________
Signature of Patient	**Print Patient's Name**	**Date of Birth**
______________________________	______________________________	______________________________
Signature of Responsible Party (if not the patient)	**Print Name of Responsible Party**	**Date of Birth**

____
Today's 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 (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 will pay for services.

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