Evan C. Merrill, DPM, FACFAS
Adam J. Gerber, DPM, AACFAS

Welcome!

Dear New Patient,

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 Details:

Day: _____ Date: _____ Time: _____ am / pm

Please arrive 15 minutes prior to your appointment time.

☐ Dr. Merrill ☐ Dr. Gerber

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 meeting and serving you!

Dr. Evan Merrill Dr. Adam Gerber

1904 E. Barnett Rd. Medford, OR 97504 • 541.776.3338 (FEET) • Fax 541.776.4979 • www.SoFootAnkle.com

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 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 _____ Level of Education _____ Student: ☐ Full time ☐ Part time

Employer_____

Primary Physician _____ Preferred Pharmacy _____

How Did You Hear About Us? _____

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, 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)

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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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