Willamette Valley
Foot & Ankle
Center, P.C.

PLEASE PRINT — PATIENT INFORMATION

LAST NAME FIRST MIDDLE	DATE OF BIRTH	AGE	SEX	MARITAL STATUS
STREET ADDRESS	CITY		STATE	ZIP
P.O. BOX	CITY		STATE	ZIP
HOME PHONE / SOCIAL SECURITY #	EMPLOYER		OCCUPATION	
ALLERGIC TO WHAT MEDICATIONS:	WORK PHONE		DEPT. OR EXT.	
REFERRED BY:	PRIMARY CARE PHYSICIAN		PHONE # PCP	

SPOUSE OR PARENT

LAST NAME FIRST MIDDLE	DATE OF BIRTH	RELATIONSHIP TO PATIENT	
ADDRESS IF DIFFERENT FROM ABOVE	CITY	STATE	ZIP
HOME PHONE / SOCIAL SECURITY #	EMPLOYER	WORK PHONE	

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY		SECONDARY INSURANCE COMPANY			
CLAIMS ADDRESS		CLAIMS ADDRESS			
CITY STATE ZIP	PHONE	CITY	STATE	ZIP	PHONE
INSURED / SUBSCRIBER NAME		INSURED / SUBSCRIBER NAME			
ID#		ID#			
GROUP OR PLAN #		GROUP OR PLAN #			

IF BILLING WORKER'S COMP COMPLETE BELOW

INSURANCE COMPANY ADDRESS	
CITY STATE ZIP	PHONE
INJURY DATE	CLAIM #
EMPLOYER	
AREA OF PAIN	

827 FILED? ☐ YES ☐ NO 801 FILED? ☐ YES ☐ NO

IF BILLING AUTO INSURANCE COMPLETE BELOW

INSURANCE COMPANY		ADDRESS	
CITY	STATE	ZIP	PHONE
CLAIM #		INSURED	
AREA OF PAIN	DATE OF ACCIDENT	CIRCLE ONE DRIVER PASSENGER	
ATTORNEY NAME		PHONE	

IN CASE OF EMERGENCY

NAME (SOMEONE OTHER THAN WHO LIVES WITH YOU)	RELATIONSHIP	PHONE

AUTHORIZATION RELEASE INFORMATION • ASSIGNMENT OF INSURANCE • AGREEMENT/CONTRACT

I hereby authorize Willamette Valley Foot & Ankle employees to release to my insurance company any information acquired in the course of my examination of treatment (if patient is a minor; parent or guardian must sign).
I hereby agree to full responsibility for all expenses by me or on behalf of the above named patient and hereby assign to Willamette Valley Foot & Ankle any and all insurance benefits due to me to fulfill my financial obligation to the treating physician or provider.
I understand my insurance coverage is a relationship between my insurance company and myself. I agree to accept financial responsibility for payment for charges incurred. I understand that a $10.00 monthly rebilling fee will be applied to balances over 30 days old, complying with Oregon State Law. In the event of non-payment I will bear the cost of collection and reasonable legal fees should this be required.

X ______________________________

SIGNATURE **DATE**

Willamette Valley Foot and Ankle Center, P.C.
Medical History

Name: ______________________ DOB:_________ Age:_____ Sex:_____ Height:______ Weight:______

Shoe Size: _______________ Type Most Often Worn: Dress Casual Activity Level: High Average Low

Describe the reason we are seeing you today. Be as specific as possible.

____

____

____

____

Please circle "Y"es or "N"o to indicate if you have or have had any of the following conditions:

Condition			Condition			Condition		
Asthma	Y	N	Congestive Heart Failure	Y	N	Migraines	Y	N
AIDS/HIV	Y	N	Coronary Artery Disease	Y	N	Mitral Valve Prolapse	Y	N
Anemia	Y	N	Diabetes	Y	N	Nervous Problems	Y	N
Artificial Heart Valves	Y	N	Dialysis	Y	N	Osteoarthritis	Y	N
Artificial Joints	Y	N	Depression	Y	N	Phlebitis	Y	N
Back Problems	Y	N	Epilepsy/Seizure Disorder	Y	N	Psychiatric Care	Y	N
Bleeding Disorders	Y	N	Esophageal Reflux	Y	N	Rheumatoid Arthritis	Y	N
Blood Clots	Y	N	Gout	Y	N	Stomach Ulcers	Y	N
Cancer	Y	N	Hemophilia	Y	N	Stroke	Y	N
Cardiac Arythmia	Y	N	Hepatitis	Y	N	Thyroid Disease	Y	N
Cataracts/ Glaucoma	Y	N	High Blood Pressure	Y	N	Tuberculosis	Y	N
Chemical Dependency	Y	N						

Other Medical Conditions:____

____

For Women:

Are you pregnant? Y N

Are you presently nursing? Y N

MEDICATIONS: Please list **ALL** prescription medications, over the counter, and vitamins.

____

____

____

ALLERGIES: Please indicate any drug allergies you have.

____

____

____

Do you use tobacco products? Y N

Packs/Day _____________ Years Smoked ________

Cigars/Day _____________ Pipe ________________

Chewing Tobacco? Y N

If you've quit, how long has it been since your last smoke?__________

Do you use alcohol products? Y N

How much do you drink? ________________________

How often do you drink? ________________________

Do you currently use, or have used in the past, any substance or any prescription narcotic in excess that may injure or may have contributed to any health problems? Y N

Willamette Valley Foot and Ankle Center, P.C.
Surgical History

Please list **ALL** surgeries EVER had:

____
____
____
____

Have you ever healed with thick, disfigured, or keloid scars?	Y	N
Have you ever had any problems with slow healing of surgical incisions?	Y	N

Family History

Please circle "Y"es or "N"o if anyone in your family has (or has had) and your relationship (i.e., mom, dad, aunt, brother):

Condition			Relationship	Condition			Relationship
Arthritis (Degenerative)	Y	N	________	High Blood Pressure	Y	N	________
Arthritis (Rheumatoid)	Y	N	________	Liver Disease	Y	N	________
Bleeding Disorders	Y	N	________	Nerve Disease	Y	N	________
Cancer	Y	N	________	Stroke	Y	N	________
Diabetes	Y	N	________	Ulcers	Y	N	________
Gout	Y	N	________	Foot Problems	Y	N	________
Heart Disease	Y	N	________	Other: ________			

Review of Systems

Please indicate any personal history below:

Constitutional Symptoms

Good general health lately	Y	N
Recent weight changes	Y	N
Fever	Y	N
Fatigue	Y	N
Headaches	Y	N

Endocrine

Glandular or hormone problems	Y	N
Excessive thirst or urination	Y	N
Heat or cold intolerance	Y	N
Skin becoming dryer	Y	N
Change in hat or glove size	Y	N

Hepatic System

Cirrhosis	Y	N
Hepatitis	Y	N
Abnormal liver enzymes	Y	N

Musculoskeletal

Joint Pain	Y	N
Joint stiffness or swelling	Y	N
Weakness of muscles or joints	Y	N
Muscle pain or cramps	Y	N
Back pain	Y	N
Cold extremities	Y	N
Difficulty in walking	Y	N

Cardiovascular

Heart trouble	Y	N
Chest pain or angina pectoris	Y	N
Palpitation	Y	N
Shortness of breath with walking	Y	N
Or lying flat	Y	N
Swelling of feet	Y	N
Swelling of ankles	Y	N
Swelling of hands	Y	N

Neurological

Frequent or Recurring headaches	Y	N
Light Headed or dizziness	Y	N
Convulsions or seizures	Y	N
Numbness or tingling	Y	N
Tremors	Y	N
Paralysis	Y	N
Head injury	Y	N

Hematologic/Lymphatic

Slow to heal after cuts	Y	N
Bleeding or bruising tendency	Y	N
Anemia	Y	N
Phlebitis	Y	N
Past transfusions	Y	N
Enlarged glands	Y	N

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services that I may need.

Patient/Guardian Signature: ______________________ Date: __________

Doctor Signature: ______________________ Date: __________

ACKNOWLEDGMENT AND CONSENT

I understand that Jeffrey R. Russo, DPM (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By:______________________________ Date:______________
(Patient)

By:______________________________ Date:______________
(Patient representative)

Description of Representative's Authority:______________________________

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