DONALD CARLSON, D.P.M.
Patient Registration Form
(Please fill out in Black Ink Only)

DATE: ___/___/___

PATIENT NAME: FIRST _____ MIDDLE INITIAL: _____ LAST: _____

DATE OF BIRTH: _____/_____/_____ AGE: ___ SEX: M F SOCIAL SECURITY #: _____

MAILING ADDRESS: _____ CITY/STATE: _____ ZIP: _____

HOME PHONE #: (_____) _____-_____ CELL #: (_____) _____-_____ E-MAIL - _____

PRIMARY CARE DOCTOR: _____

PRIMARY LANGUAGE: _____ RACE: _____ ETHNICITY: ○ HISPANIC ○ NOT HISPANIC

PHARMACY: _____ CITY: _____

IN CASE OF EMERGENCY: _____ RELATIONSHIP: _____ PHONE #:_____

MARRIED _____ SINGLE _____ WIDOWED _____ DIVORCED _____ OTHER _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

SUBSCRIBER NAME: _____ DATE OF BIRTH: _____EMPLOYER:_____

MEMBER ID # _____ GROUP # _____

RELATIONSHIP TO INSURED: _____

SECONDARY INSURANCE COMPANY NAME: _____

SUBSCRIBER NAME: _____ DATE OF BIRTH: _____ EMPLOYER: _____

MEMBER ID #:_____ GROUP # _____

RELATIONSHIP TO INSURED: _____

RESPONSIBLE PARTY (If other than patient)

NAME: FIRST _____ MIDDLE INITIAL: _____ LAST: _____

MAILING ADDRESS: _____

CITY STATE ZIP

HOME PHONE: (_____) _____ - _____ WORK PHONE # (_____) _____ - _____

DATE OF BIRTH: ____/____/_____ SOCIAL SECURITY #: _____

PATIENT HISTORY

ALLERGIES: [ ] NONE KNOWN **PATIENT NAME**: _____

[ ] MEDICATION ALLERGIES: _____

[ ] ANESTHESIA ALLERGIES: _____

[ ] FOOD ALLERGIES: _____

OTHER: _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

HAVE YOU OR ANY OF THE FOLLOWING FAMILY MEMBERS HAD ANY OF THE FOLLOWING CONDITIONS (PLEASE MARK AS FOLLOWS):

MEDICAL HISTORY: FATHER (**F)** MOTHER (**M)** SISTER (**S)** BROTHER (**B)** PATIENT (**P)**

[ ] ABNORMAL BLEEDING	**[ ] CANCER**	**[ ] LIVER DISEASE**	**[ ] SKIN DISORDER**
[ ] ACID REFLUX	**[ ] DIABETES**	**[ ] LOW BLOOD PRESSURE**	**[ ] SLEEP APNEA**
[ ] ANEMIA	**[ ] FIBROMYALGIA**	**[ ] MIGRAINE HEADACHES**	**[ ] STOMACH ULCERS**
[ ] ARTHRITIS	**[ ] GOUT**	**[ ] MITRAL VALVE PROLAPSE**	**[ ] STROKE**
[ ] ASTHMA	**[ ] HEART ATTACK**	**[ ] NEUROPATHY**	**[ ] THYROID DISEASE**
[ ] BACK TROUBLE	**[ ] HEART DISEASE/FAILURE**	**[ ] OPEN SORES**	**[ ] TUBERCULOSIS**
[ ] BLADDER INFECTIONS	**[ ] HEPATITIS**	**[ ] PNEUMONIA**	**[ ] NONE**
[ ] BLOOD CLOTS	**[ ] HIV/AIDS**	**[ ] POLIO**	
[ ] BLOOD TRANSFUSION	**[ ] HIGH BLOOD PRESSURE**	**[ ] RHEUMATIC FEVER**	
[ ] BRONCHITIS/EMPHYSEMA	**[ ] KIDNEY DISEASE**	**[ ] OTHER _____**	

[ ] ARE YOU CURRENTLY PREGNANT OR NURSING (PLEASE CIRCLE)

PLEASE PRINT ALL PRIOR SURGERIES:

TYPE OF SURGERY DATE

_____

SOCIAL HISTORY:

TOBACCO USE: [ ] NEVER [ ] FORMER [ ] SOMETIME [ ] EVERYDAY

OCCUPATION: _____ EMPLOYER: _____

WORK ACTIVITY: _____

WEIGHT: _____ HEIGHT**:** _____ SHOE SIZE: _____

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name (please print) **Date**

_____

Parent or Authorized Representative (if applicable) (Please Print)

_____

Patient/Parent Signature

I authorize the following person to have access to my medical records.

Name: _____ Relationship: _____

Patient's signature: _____

Hermiston Family Foot Clinic LLC does not leave voice mail messages about your personal health, on your telephone without your permission.

If permission to leave a private voice mail message is given, the message may include information about:

☐ **Illness or injury**	☐ **Medications**	☐ **Test results**
☐ **Treatment**	☐ **Appointments**	☐ **Billing and Insurance**

OFFICE POLICIES

1. **Our office policy requires new patients to pay $185.00 towards your first visit. Once all insurances have paid in full any refund due you will be paid by check and will take two or more billing cycles. This does not apply to Medicare or State Medicaid patients.**
2. Co-pay must be paid at time of service.
3. If you are more than 10 minutes late for your appointment, you must reschedule.
4. If you are unable to keep an appointment, please give 24 hours notice. **Failure to do so will result in a $60.00 appointment charge. This is not covered by insurance and will be your responsibility. There will be a $25.00 rebilling charge until paid. 2 missed appointments could result in being dismissed from our office.**

AUTHORIZATION/FINANCIAL RESPONSIBILITY

I hereby assign to Donald J. Carlson, D.P.M. all benefits provided by my insurance policy (including Medicare, private insurance and Oregon Health Plans) for medical/surgical care but not exceeded charges stated for such services rendered. I understand that I am responsible for the charges of any medical/surgical services rendered regardless of my insurance coverage. **I also understand that I will be responsible for paying within 60 days of date of service. NSF-there will be a $35 charge**. I hereby authorize Donald J. Carlson, D.P.M. to release information regarding the patient to the insurance company(s) and/or primary care physician.

Patient/Guardian Signature: _____ Date: _____