NORTHWEST EXTREMITY
SPECIALISTS

Name: _____ Date of Birth: _____
First Middle Initial Last

Age: _____ Social Security #: _____What is your assigned gender? Male/Female

What is your preferred Gender? Male/Female/Other: _____

Mailing Address: _____ City: _____

State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Email: _____ Contact by email? Yes/No

Marital Status(circle one): Single Married Domestic Partner Widowed Legally Separated Divorced

Race(circle all that apply): White Black/African American Asian Hispanic Native American Native Hawaiian/Pacific Islander Declined

Ethnicity(circle one): Not Hispanic/Latino Hispanic/Latino Declined

Preferred Contact (circle one): Phone- home/mobile/work Email Text

Employer: _____ Occupation: _____Phone:_____

Spouse/Parent/Guardian: _____Phone:_____Employer: _____

Emergency Contact Name: _____Relationship: _____Phone:_____

Primary Care Physician: _____ Phone: _____

Date Last Seen: _____

Whom may we thank for referring you:

Physician/Clinic Name: _____(first & last name, clinic name)

Another Patient:_____

(circle) Internet Insurance Hospital Family/Friend Other: _____

****

ASSIGNMENT AND RELEASE:

I give permission to Northwest Extremity Specialists, LLC to administer treatment and to perform such procedures as may be necessary in my diagnosis and/or treatment. I also give my permission to electronically check my medication history.

_____

Patient Name (please print) Patient/Guardian Signature Date

Patient Name: _____ Date of Birth: _____

REASON FOR TODAY'S VISIT

Injured Body Part (foot, leg, ankle):_____
_____
(circle all that apply)
Date of Onset/Injury: _____Pain Level: None 1 2 3 4 5 6 7 8 9 10 (worst) **Location:** R / L / Both
Type of Pain: Sharp Burning Dull Aching Intermittent Constant Throbbing Shooting
Onset: Slow Sudden Traumatic **Is Pain Getting:** Worse Better No Change
Prior Treatments: _____
What makes it worse: Walking Running Standing Shoes Other: _____
Is this a work related or Motor vehicle injury? Yes/No **Is this a second opinion?** Yes/No
Previous Physician Treating Injury: _____
Vein Screening Questionnaire:
Are your legs heavy, tight, tired, dull or achy? Yes/No
Do you have swelling in the legs and/or ankles and/or varicose veins? Yes/No
Is the skin just above the ankle brownish-red or discolored? Does it feel leathery, hard, or itchy? Yes/No

MEDICAL HISTORY

Height: _____ Weight: _____ Shoe Size: _____ BP: _____ Pulse: _____

Medications	Allergies
Include Prescriptions, over-the-counter medications and vitamins (please provide a list or attach an additional page if necessary): _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ Pharmacy Name(s): _____ Pharmacy Phone(s): _____ Do you take oral contraceptives? Yes ___ No___	(circle all that apply) NO ALLERGIES Adhesive/Tape Local Anesthetics Anticoagulant Therapy Novocaine Aspirin Penicillin Codeine Seafood Demerol Sulfa Iodine Latex Metal/Nickel Other _____

SOCIAL HISTORY: Alcohol use/frequency: _____ Drug Use/Frequency: _____
SMOKING STATUS (circle one): Current Everyday/Current Someday/Former Smoker/Never Smoked/Unknown

Hospitalizations/Surgeries (last 10 years): _____
_____

FAMILY HISTORY (circle all that apply): Heart Disease Early Deaths Bleeding High Blood Pressure
Asthma COPD High Cholesterol Thyroid Disorder Osteoporosis Diabetes Stroke Cancer
(other)_____

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Patient Name: _____ Date of Birth: _____

Active Medical Problems

(circle all that apply)
AIDS/HIV Anesthesia Problems Artificial Heart Valves Artificial Joints Bipolar Disease Bleeding Problems Cancer Circulatory Problems Hepatitis Hiatal Hernia High Blood Pressure High Cholesterol Infections Neuropathy Pacemaker Prostate Problems Seizures Sexually Transmitted Disease Sleep Apnea Snoring Thyroid Problems TMJ Tuberculosis

Are You Currently Experiencing Any of the Following Symptoms?

General: Fatigue Fever Chills Sweating Heavily at Night Recent Weight Loss Recent Weight Gain

Head: Headache Sinus pain

Eye: Worsening vision Floaters Double vision Blurry Vision Pain w/Eye Movement Red Eyes Sensitivity to Light Glasses Contacts Glaucoma Dry Eye Loss of Vision

ENT: Hearing Loss Earache Draining from Ear or Nose Ringing in Ear(s) Sneezing Nasal Itching Sore Throat Mouth Sores Dry Mouth Difficulty Swallowing

Cardiovascular: Chest Pain Crushing Chest Pain Heart Palpitations Leg Pain w/Exercise Heart Attack Heart Disease Angina Congestive Heart Failure

Pulmonary: Difficulty Breathing Shortness of Breath Wheezing Orthopnea Cough Loose Cough Dry Cough Coughing up Blood Asthma

GI: Decreased Appetite Anorexia Heartburn Nausea Vomiting Abdominal Pain Jaundice Diarrhea Constipation Ulcers

GU: Blood in Urine Urine odor abnormal Painful Urination Change in Urine Frequency Frequent or Excessive Nighttime Urination Incontinence Urinary Urgency Kidney Problems Liver Disease Blood in Urine/Stool Dialysis

Endocrine: Diabetes Mellitus Excessive Thirst Heat Intolerance Cold Intolerance Excessive Sweating Feelings of Weakness

Musculoskeletal: Back pain Muscle Aches Muscle Cramps Joint Pain Joint Swelling Joint Stiffness Arthritis

Neurologic: Dizziness/Vertigo Fainting Confusion Memory Loss Speech Disturbance Limb Weakness Paralysis Tingling Involuntary Movements Balance Problems Numbness □Stroke

Psychological: Anxiety Depression

Skin: Dry Skin Itching Peeling of Skin Skin Scaling Rash Skin Discoloration

NORTHWEST EXTREMITY SPECIALISTS

Podiatric Physicians and Surgeons

Jason Surratt, DPM
Thomas Melillo, DPM
Peter Pham, DPM
Yama Dehqanzada, DPM
Todd Galle, DPM
Mia Horvath, DPM
Lacy Beth Lockhart, DPM
Clifford Mah, DPM
Denny Le, DPM
Manny Moy, DPM
Cara Beach, DPM
Lauren Eller, DPM
Lisa Yoon, DPM

Notice of Privacy Practices Patient Acknowledgement

I have received this practices' Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices upon request.

Signature: _____ Relationship to patient: _____ Date: _____

Please indicate below the name(s) of any person(s) you allow Northwest Extremities Specialists, LLC to disclose personal/medical information to.

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

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FINANCIAL POLICY

Patient Name: _____ Date of Birth: _____

Welcome to Northwest Extremity Specialists, LLC. Thank you for choosing us as your podiatric physician. We are committed to your treatment being successful, as you, the patient, are our first and foremost concern. The following is a statement of our Financial Policy which we request you read, initial and sign prior to any treatment. To avoid any misunderstandings, please contact us should you have any questions about our policies.

INSURANCE: Your insurance policy is a contract between you and your insurance company, therefore you are responsible whether or not your insurance pays. If we are participating with your insurance plan, we will submit the claim to your insurance. In order to do this, we will need complete and accurate insurance information including social security number, home address, phone number, insurance claim mailing address, insurance phone number, subscriber ID number and/or group number. (This may be obtained by providing a copy of the front and back of your insurance card). This should be provided for each insurance plan you are currently effective with. **_____initials**

NON-INSURED: If you do not have insurance or the doctor is not a participating provider with your insurance plan, full payment is due at the time of each visit. **_____ initials**

PAYMENT: Payments for any co-pays, deductibles, balance due, etc., is due at the time of service. You will receive a statement showing itemized charges and payments monthly. A $35 charge will be applied to your account for any returned checks. **_____ initials**

MINOR PATIENTS: The adult or the parent (custodial guardian) accompanying a minor is responsible for payment of services. For unaccompanied minors, non-emergency treatment will be denied unless prior authorization from the parent or guardian has been made for the charges and treatment. Young adults (age 18 & over) are legally responsible for their accounts unless a parent accompanies them to the initial appointment and signs this financial agreement, regardless of insurance coverage. **_____ initials**

MISSED APPOINTMENTS: Please help us serve you better by keeping scheduled appointments. If it is necessary to cancel, please call our office 24 hours in advance. This allows us to accommodate our other patients. A $35 charge may be assessed for missed appointments. **_____ initials**

REFERRALS: It is your responsibility to obtain any required referral from your insurance company. Failure to do so may reduce the amount of benefits paid by your insurance, in turn increasing the patient responsibility. Please be aware that if you choose to be seen before you have received a valid referral, your insurance may not pay for services rendered. **_____ initials**

COLLECTIONS: Account balances 60 days old are considered past-due. Account balances 90 days old are considered delinquent. Account balances 120 days or older will be referred to a third party collection agency. However, we do reserve the right to send any account to collections, regardless of the amount of days past due. Payment plans can be arranged with our business office if you are not able to pay the balance in full. **_____ initials**

SUPPLIES: For your convenience we make some supplies available for purchase in the office. If you choose to purchase these items, payment is due at the time of purchase. **_____ initials.**

By signing below, I understand the above information pertaining to the financial policy at Northwest Extremity Specialists, LLC and agree to adhere to the patient responsibility requirements.

_____

Patient Name (please print) Patient/Guardian Signature Date