DONALD CARLSON, D.P.M.
Patient Registration Form

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: ____________________

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 #: __________________________________

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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):

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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**) BROTHER (**B**) SISTER (**S**) 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 ____________________**	

PLEASE PRINT ALL PRIOR SURGERIES:

TYPE OF SURGERY DATE

____

SOCIAL HISTORY:

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

OCCUPATION: ____

WORK ACTIVITY: ____

WEIGHT: ______________________________ HEIGHT**:** ______________________________ SHOE SIZE: ________________________

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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)

____
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 $175.00 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 $40.00 appointment charge. This is not covered by insurance and will be your responsibility. There will be a $15.00 rebilling charge until paid.**

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: ________________

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