Northwest Footcare, LLC

Bryan D. Wilhelm, DPM Nat Chotechuang, DPM Frank R. Cobarrubia, DPM Amanda Westfall McCarty, DPM

How did you first hear about us?
[ ] Internet [ ] Friendly referral [ ] Dr. Referral, whom _____ [ ] Other_____

Contact Information

Patient Name _____ Date of Birth_____

Preferred Name_____ Gender_____ Pronouns_____

Email_____

Home address_____

City _____ State _____ Zip_____

Mailing address_____

Primary Phone _____ Work Phone_____

Social Security #_____ Occupation_____

Employers Name and Address_____

Primary Insurance _____ Secondary Insurance_____

Would you like appointment reminders? [ ] text message [ ] voice message [ ] email

Person responsible for this bill (If different than above)

Name_____ Date of Birth_____

Mailing address_____

City _____ State _____ Zip_____

Home Phone_____ Work Phone_____

Social Security #_____ Relationship_____

Agreement and Consent

I authorize the release of any medical information necessary to process insurance claims. I also authorize payment of medical benefits directly to Northwest Footcare, LLC for professional services rendered. I understand that Northwest Footcare, LLC will bill my insurance as a courtesy, but I am responsible for any balance not covered by my insurance.

I acknowledge that both the Financial Policy and Notice of Privacy Practices from Northwest Footcare, LLC have been made accessible to me and I agree to the terms. I also acknowledge that Northwest Footcare, LLC may leave detailed messages on my telephone unless I specify otherwise.

I give permission to the physicians at Northwest Footcare, LLC to administer treatment and to perform such procedures as maybe deemed necessary or advisable in the diagnosis and/or treatment of the foot and related conditions after I have consented. By Oregon law, I am entitled to know the procedure, alternatives and risks involved, with a detailed explanation if so desired.

I understand that undesirable outcomes MAY OCCUR with procedures and adverse side effects or reactions MAY OCCUR with medications. I will be responsible for following the doctor's instruction and that my non-compliance may result in a poor outcome and may be grounds for termination of the doctor/patient relationship. I will also be responsible for continuing any recommended follow up care and for any poor outcome which may result from the lack of doctor recommended follow up care.

I understand that if I do not show up to my appointment, I will incur a $25 fee.

_____

Signature of Patient or Responsible Party Date

Northwest Footcare, LLC
Comprehensive Health Review

Patient name:_____ Date of Birth:_____ Today's Date:_____

Age:_____ Height:_____ Weight:_____ Shoe size:_____ Gender: _____

Primary care provider name and clinic:_____

HISTORY OF PRESENT ILLNESS

Describe your foot or ankle issue: _____

Which foot and/or ankle is involved? ❑ Left ❑ Right ❑ Both

Is this problem work-related (i.e., is it Workers' Comp)? ❑ Yes ❑ No

When did the problem begin? _____

Do you know what caused the problem? ❑ Yes ❑ No. If yes, what was the cause? _____

What makes it better? _____ What makes it worse? _____

Is the problem painful? ❑ Yes ❑ No

If painful, how severe is it? (none) 0 1 2 3 4 5 6 7 8 9 10 (extreme)

What treatments have you tried, if any? _____

MEDICAL HISTORY (check all that apply)

❑ Alzheimer's/dementia
❑ Arthritis
❑ Anxiety
❑ Autoimmune disease
❑ Blood clot/DVT
❑ Cancer
❑ Congestive heart failure
❑ Diabetes
❑ Depression
❑ Fibromyalgia
❑ Gout
❑ Heart disease
❑ Hepatitis
❑ High cholesterol
❑ HIV/AIDS
❑ Hypertension
❑ Osteoporosis
❑ Peripheral arterial disease
❑ Pregnant (currently)
❑ Sleep apnea
❑ Stomach ulcers
❑ Thyroid (❑ low ❑ high)
❑ Other problems not listed:
_____
_____
_____

PAST SURGERIES

Please list: _____

FAMILY HISTORY

❑ Cancer ❑ Diabetes ❑ Heart disease ❑ Other: _____

ALLERGIES and reaction

Please list: _____

Northwest Footcare, LLC
Comprehensive Health Review

MEDICATIONS (or provide list)

_____ _____
_____ _____
_____ _____
_____ _____

SOCIAL HISTORY

I use Tobacco: ❑ Yes ❑ No
I drink Alcohol: ❑ Yes ❑ No How much? _____
I use recreational and/or illicit drugs: ❑ Yes ❑ No
Occupation: _____ ❑ Mostly seated ❑ Mostly standing ❑ Lots of walking
Activities/Sports: _____

REVIEW OF SYSTEMS (please check box if you currently have any of the following)

GENERAL
❑ Fever/Chills
❑ Nausea/Vomiting

EYES/EARS/NOSE//THROAT
❑ Hearing loss
❑ Sore Throat

CARDIOVASCULAR
❑ Chest pain
❑ Leg pain when walking
❑ Poor circulation
❑ Swelling in legs and feet

RESPIRATORY
❑ Shortness of breath
❑ Chronic cough
❑ Difficulty breathing

GASTROINTESTINAL
❑ Digestive disorder
❑ Blood in stool

GENITOURINARY
❑ Frequent urination
❑ Blood in urine
❑ Kidney stones

INTEGUMENTARY
❑ Rash
❑ Dry, scaly skin
❑ Athlete's foot

MUSCULOSKELETAL
❑ Back pain
❑ Joint stiffness
❑ Joint pain

ENDOCRINE
❑ Hormone imbalance
❑ Too hot/Too cold
❑ Excessive thirst
❑ Excessive urination

NEUROLOGICAL
❑ Numbness/Tingling
❑ Dizziness
❑ Tremors
❑ Restless leg

PSYCHIATRIC
❑ Insomnia
❑ Confusion
❑ Memory loss

HEMATOLOGIC
❑ Bruise easily
❑ Bleed easily
❑ Use of blood thinners

IMMUNOLOGIC
❑ Weakened immune system
❑ Swollen lymph nodes

The information I have provided is true and accurate to the best of my knowledge. I recognize that the information I have provided will help me receive better care.

X _____ _____
Patient/Guardian Signature Date