Willamette Foot & Ankle
Myles Knutson, DPM

311 B Ave, Suite S Lake Oswego, OR 97034
503-804-7579 ▪ F: 833-450-4775 ▪ willamettefootandankle.com

New Patient Registration

Patient Information:

First Name_____ Last Name _____
Preferred Name_____ Date of Birth_____
Age _____
Gender_____ Gender Identity_____
Do you have Preferred Pronouns? _____

Address_____
City _____ Zip Code _____

Preferred Phone Number: _____
☐Mobile ☐Home

Email: _____

Preferred Pharmacy:
_____ (name, city, street name)

Emergency Contact:

Name_____ Relationship_____
Contact phone Number _____

Insurance:

Primary Company Name _____
Secondary Name _____
Subscriber: ☐Self
☐Other:_____ (Name & Date of Birth)
_____

Referral Information:

Who referred you?
☐Primary Care Doctor
☐Hospital Referral _____
☐UrgentCare Referral _____
☐Physical Therapist _____
☐Internet Search _____
☐Friend/Family_____
☐Other: _____

How quickly were you able to be seen?
☐Next Day ☐Quick ☐Slow ☐Long wait

Who is your Primary Care Provider?_____
What is the name of their Clinic? _____

Which hospital system do you use most often?
☐Legacy ☐Providence ☐OHSU

Racial & Ethnic Background:

The US HITECH Act requires us to ask the following questions

Preferred Language: ☐English Other: _____

Check all that you identify with:
☐Asian ☐Black / African American
☐Caucasian / White ☐Hispanic / Latino
☐Native American ☐Native Pacific Islander
☐Decline

Past Medical History

General:

Weight: _____ Height:_____

Shoe Size _____

Drug Allergies:

☐ **No Known Allergies**

☐ Penicillin ☐ Sulfa ☐ Iodine
☐ Aspirin ☐ Codeine ☐ NSAIDs
☐ Local Anesthetic ☐ Adhesive Tape
☐ Metal Allergy_____

Other:

Medications:

☐ **No Medications**

List all medications:_____

_____

_____

_____

_____

_____

☐ **See Attached List**

(List can be uploaded to form)

Surgeries:

List surgeries, serious injuries, or major hospital stays

☐ **No Previous Surgeries**

_____

_____

_____

_____

_____

Medical Conditions:

☐ **No medical conditions diagnosed by Doctor**

☐ Anemia ☐ Anxiety ☐ Artificial Valve
☐ Arthritis ☐ Asthma ☐ Back Problem
☐ Cancer ☐ Chest Pain ☐ Circulation Problems
☐ Depression ☐ Diabetes ☐ Epilepsy
☐ Fibromyalgia ☐ Gout ☐ Heart Disease
☐ Heart Attack ☐ Hepatitis ☐ High Blood Pressure
☐ HIV ☐ Kidney Problems ☐ Leg Cramps
☐ Liver Disease ☐ Lung Disease ☐ Mental Illness
☐ Phlebitis / Blood Clots ☐ Psoriasis
☐ Psychiatric ☐ Rheumatologic Condition
☐ Stroke ☐ Thyroid Problems ☐ Ulcers(stomach)

Arthritis? (List type) _____
Diabetes? (Type & Last Known A1C)_____
Cancer? (List type) _____
Psychiatric (list condition)_____

Other:

Family History: (mother or father)

☐ Diabetes ☐ Bloodclotts ☐ Heart Disease
☐ Stroke ☐ Rheumatoid ☐ Gout

Other:

Social History:

Occupation: _____

Do you Smoke or use Nicotine? **No** / Yes

Past Smoker / Nicotine? **No** / Yes

If yes, How much per day?_____

If yes, How Many years? _____

Do you use Recreational Drugs? **No** / Yes

If yes, list types _____

Pregnant or Possibly Pregnant? **No** / Yes

History of Current Condition

What is your main reason for seeking medical attention? (in 1-2 sentences)

_____

_____

Which Side:

☐ Left ☐ Right ☐ Both

What part of the Foot / Ankle?

☐ Small Toes ☐ Big Toe ☐ Ankle ☐ Arch
☐ Bottom Heel ☐ Back Heel ☐ Achilles ☐ Top of foot
☐ Ball of foot ☐ Outer foot ☐ Inner ankle ☐ Outer ankle
Other:

Type of Pain:

☐ Dull ☐ Achy ☐ Throbbing ☐ Numb
☐ Burning ☐ Sharp ☐ Stabbing ☐ Pressure

How long has it been a problem?

____ Days ____Weeks ____Months ____Years
Approx date of onset _____

How has it progressed ?

☐ Improved some ☐ No improvement ☐ Worsen
☐ Intermittent ☐ Unsure

What aggravates the condition ?

☐ Shoes ☐ Activity ☐ Barefoot
☐ Running ☐ Standing ☐ Walking
☐ Pain after first stepping
Other:

How did it begin?

☐ Slow onset ☐ Sudden ☐ Known Injury
☐ Known Trauma ☐ Old injury ☐ Bad Shoes
☐ After an Activity ☐ Twist ☐ Barefoot
Other:

What treatments have you tried?

☐ Changing shoes ☐ Anti-inflammatory med
☐ Ice ☐ Decreasing activities
☐ Heat ☐ Message
☐ Stretching ☐ Physical Therapy
☐ Padding ☐ Injections
☐ Antibiotics ☐ OTC Meds
☐ Prefabricated Arch Supports
☐ Custom Orthotics
Other:

What seems to help?

_____

_____

Have you seen another healthcare provider for this?

☐ No ☐ Yes ☐ Second Opinion
If yes, what specialty? _____
How long ago? _____
What did they offer? _____

Exercise and Orthotics:

What exercise do you routinely do? _____

_____

Number of days per week for exercise? _____

_____

What activities does your foot prevent you from doing?

_____

Do you use store bought arch supports? Yes / No

Do you use Custom Orthotics? Yes / No

Are you interested in Orthotics? Yes / No / Unsure

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Insurance Card Copies

In order to confirm and hold your appointment time we need to have a copy of the front and back of your insurance card. This is needed to confirm your active insurance status and confirm your eligibility.

We have 2 options for sending us the card images.

Do one of the following:

1) Send photos as a Text Message. Send a photo of the front and back of the card to our office number. The number receives text messages.

Office Number: 503-804-7579

2) Send an email of images / file to our email.

Contact@willamettefootandankle.com

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Missed Appointment Policy

As a courtesy, and to help patients remember their scheduled appointments, we send multiple text messages and email reminders. If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to those patients who are waiting to schedule with the physician, please give us at least 24 hours notice.

If for any reason you need to cancel or change your appointment you must do so 24 hours before the scheduled appointment time. Please call or message for changes. Any cancellations or no shows made less than 24 hours will be charged a **$60 late cancel/no show fee.** We acknowledge that extenuating circumstances do occur and are considered on a case by case basis.

Responsible Party: (If not Patient) _____

By signing this agreement, you agree to all the terms and conditions as indicated above.

Signature:_____
Date:_____

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Financial Policy

INSURANCE POLICY

Your insurance policy is a contract between you and your insurance company, therefore you are responsible whether or not your insurance pays. The amount owed is based on your deductible and coinsurance. If we are participating with your insurance plan, we will submit the claim to your insurance. We recommend calling your carrier to confirm coverage, review your deductible, and verify Dr Knutson is in network for your plan.

ACCURATE INSURANCE INFORMATION

In order to submit insurance claims on your behalf we will need complete and accurate insurance information including: home address, phone number, insurance claim mailing address, insurance phone number, subscriber ID number and group number, subscriber date of birth. If any changes are made to the information, it is the patient's responsibility to inform the clinic to avoid additional charges. We are required to have a copy of your insurance card(s) on file in order to to bill your insurance for you. If we do not have this accurate information on file, you will be billed directly and are responsible for all charges.

RELEASE OF BENEFITS INFORMATION

I authorize my insurance benefits to be paid directly to the doctor. I understand that the doctor's office will bill my insurance as a courtesy and that I am responsible for all co-payments, deductibles and non-covered services. I authorize the release of information required to process my claims. ALL CO-PAYMENTS DUE ON DAY OF SERVICE.

PATIENT ACCOUNT BALANCES:

Past due accounts: We will notify you of patient statements by mail and email. If the account becomes past due additional phone calls, emails, and text messages will be sent. If full payment is not made or a payment plan is not established, your account will be sent to collections.

Patient's Name:_____

Responsible Party: (If not Patient) _____

By signing this agreement, you agree to all the terms and conditions as indicated above.

Signature:_____ Date:_____

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HIPPA Policy

Health Information Privacy Protection Act

We follow HIPPA Policies set forth by the Oregon Health Authority. In general, HIPPA gives individuals the right to request restrictions on uses and disclosures of their protected PHI (protected health information). The individual is also provided the right to request confidential communications. We keep a record of the healthcare services we provided for you. You may ask to see and copy the record. You may also ask to correct the record. We will not disclose your record to others unless you direct us to do so, or unless law authorities require us to do so.

For a full description visit Oregon.gov/OHA or
https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/oe2090.pdf

I authorize communication to be sent to myself over the following means:

1) ANY FORM IS OK
2) Text Message
3) Email
4) Phone Call
5) Voicemail

Patient's Name:_____

Responsible Party: (If not Patient) _____

By signing this agreement, you are aware of the HIPPA Policy for this office.

Signature:_____ Date:_____