CASCADE FOOT & ANKLE CLINIC

KELLEY GILLROY, D.P.M, F.A.C.F.A.S.
ABE BAGNIEWSKI, D.P.M.
Physicians and Surgeons of the Foot & Ankle

PATIENT INFORMATION

PATIENT LEGAL NAME: (FIRST/M.I./LAST)					DATE:
ADDRESS:					DATE OF BIRTH:
CITY:		STATE:	ZIP:		EMAIL:
PHONE: ( )		CELL PHONE: ( )			SOCIAL SECURITY #:
GENDER:	AGE:	SHOE SIZE:	HEIGHT:	WEIGHT:	MARITAL STATUS: S ☐ M ☐ W ☐ D ☐
PATIENT EMPLOYER:				OCCUPATION:	
EMERGENCY CONTACT PERSON:		RELATIONSHIP TO PATIENT:		PHONE: ( )	

MINOR INFORMATION

PARENT/LEGAL GUARDIAN NAME: (FIRST/M.I./LAST)	RELATIONSHIP TO PATIENT:	SOCIAL SECURITY #:

INSURANCE INFORMATION

Are you/the patient at a skilled nursing facility under your Part A Medicare benefits? ☐ Yes ☐ No
If so, which facility are you residing at? _____
Are you/the patient being seen for a work related injury or Motor Vehicle Accident? ☐ Yes ☐ No

PRIMARY INSURANCE:	POLICY/SUBSCRIBER #:	GROUP #:
POLICY HOLDER'S NAME: (FIRST/M.I./LAST)	BIRTHDATE:	RELATIONSHIP TO PATIENT:
SECONDARY INSURANCE:	POLICY/SUBSCRIBER #:	GROUP #:
POLICY HOLDER'S NAME: (FIRST/M.I./LAST)	BIRTHDATE:	RELATIONSHIP TO PATIENT:
TERTIARY INSURANCE:	POLICY/SUBSCRIBER #:	GROUP #:
POLICY HOLDER'S NAME: (FIRST/M.I./LAST)	BIRTHDATE:	RELATIONSHIP TO PATIENT:

PHYSICIAN/PHARMACY INFORMATION

PRIMARY CARE PHYSICIAN: REFERRED BY PHYSICIAN: YES / NO
PHARMACY (NAME AND INTERSECTION):

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PLEASE CHECK ALL THAT APPLY

MEDICAL HISTORY:

□ Diabetes □ High Blood Pressure □ Arthritis □ Kidney Disease □ Liver Disease □ Heart Disease □ Emphysema/COPD □ Congestive Heart Failure □ Anesthesia Reactions □ Acid Reflux
□ Cancer (type: _____) □ Fibromyalgia □ Hypothyroidism □ High Cholesterol
□ Gout □ Autoimmune Disease (type: _____)
□ Other_____

_____

SURGICAL HISTORY:

□ Tonsillectomy □ Appendectomy □ Hernia Repair □ Hysterectomy □ Knee Replacement
□ Gall Bladder Removal □ Bladder Suspension □ Foot Surgery □ Cardiac Bypass □ Back surgery
□ Other_____

_____

FAMILY HISTORY:

□ Diabetes □ Heart Disease □ High Blood Pressure □ Arthritis □ Cancer (type) _____
□ Other_____

SOCIAL HISTORY:

□ Alcohol (amount/day/week) _____
□ Smoking (amount/day) _____
□ Number of Years You Have Smoked_____
□ Drug use (including marijuana) _____

CURRENT MEDICATIONS (with dosage): _____

_____

_____

ALLERGIES/REACTIONS: _____

_____

_____

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GENERAL HEALTH (CHECK ALL THAT APPLY)

REASON FOR TODAY'S VISIT:

_____

_____

WHERE DID YOU HEAR OF OUR CLINIC?

□ Doctor's Office □ Friend/Family □ Google Search □ Phone Book □ Other: _____

HAVE YOU EVER BEEN TREATED BY A PODIATRIST?
□ Yes □ No Date of Last Visit: _____

FEMALES ARE YOU:
□ Pregnant □ Nursing □ Birth Control Pills □ None
□ Other Relevant Information: _____

CONSTITUTIONAL - RECENT:
□ Fever □ Chills □ Dizziness □ Fatigue

EYES, EARS, NOSE, THROAT:
□ Glaucoma □ Cataracts □ Blurry Vision
□ Ringing Of Ears □ Hearing Impairment □ Difficulty Swallowing

CARDIOVASCULAR:
□ Heart Attack □ Stroke □ Blood Clot □ Clotting Disorder □ Varicose Veins □ Edema in legs
□ Murmur □ Excessive Bleeding □ Raynauds
□ Chest Pain □ Bad circulation to feet

RESPIRATORY:
□ Asthma □ Shortness of Breath □ Sleep Apnea □ Snoring

GASTROINTESTINAL:
□ Nausea □ Vomiting □ Diarrhea □ Stomach Ulcers □ Blood in Stools □ Colitis □ GERD

GENITO/URINARY:
□ Painful or Frequent Urination □ Impotence □ Blood in Urine
□ Sexually Transmitted Disease_____

MUSCULOSKELETAL:
□ Foot pain □ Muscle Weakness □ Joint Pain □ Low back pain or herniated disc □ Gout

SKIN:
□ Eczema □ Psoriasis □ Athlete's Foot □ Dermatitis □ Rash □ Ulcer □ Thick toenails

NEUROLOGICAL:
□ Peripheral Neuropathy □ Numbness □ Burning □ Stabbing Pains □ Sciatica
□ Seizures □ Tremors

PSYCHIATRIC:
□ Anxiety □ Depression □ Drug/Alcohol Addiction □ Paranoia □ PTSD
□ Other_____

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PAYMENT AGREEMENT

I understand that I am required to present at the time of my appointment, current insurance coverage and billing information. I understand that it is my personal responsibility to know what services my insurance covers and the amount of my co-payment. I understand my co-payment and any outstanding balance on my account is due at the time of service. I understand that any returned checks have a $45.00 fee that I am responsible for.

In the event that I do not present my current medical insurance card and/or current billing information, I understand that I am financially responsible to Cascade Foot & Ankle Clinic for the full amount of services rendered at this visit and future visits.

I acknowledge that I, or my dependent, have current insurance coverage and assign all insurance benefits directly to the physician providing treatment, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

I hereby authorize the doctor to release all information necessary to secure payment benefits. I authorize the use of this signature on all insurance submissions. In the event legal action should become necessary to collect any unpaid balance due for medical services rendered to me or my dependents, I/we agree to pay reasonable attorney fees or other such costs as the Court determines proper. I agree that the venue for any legal action shall be in Thurston County.

NO SHOW/CANCELLATION POLICY

We request a 24 hour notice for canceling or rescheduling your appointments. If you fail to provide this notice or no show for your appointment, a $30dollar charge will be assessed to your account.

By my signature, I acknowledge and understand this payment agreement.

Patient or legally authorized individual signature Date

Printed name if signed on behalf of the patient Relationship to patient (Parent, guardian, representative)

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NOTICE OF PRIVACY PRACTICES-ACKNOWLEDGEMENT

We keep a record of the health care services we provide for you. With valid identification, you may ask to see that record and request that we provide a copy for you. There will be a minimum charge if copies of your record are required. We will not disclose your record to others unless you direct us to do so, or unless the law compels us to do so. You may see your record or get more information about it by contacting our office staff.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

Please check how you would like us to contact you regarding your health care information from this office.

***It is okay to leave a detailed message on my voicemail or answering machine. This message may include specific health information. i.e. lab results, medications. Yes____ No_____

***It is okay to send and/or leave a message via email, text or by phone including appointment reminders/confirmations. Yes_____No_____

***It is okay to call me at work regarding healthcare information. Yes_____ No _____

***It is okay to leave a message with person specified regarding my healthcare information (Please specify below). Yes____ No____

Name: _____ Relationship: _____

By my signature below, I acknowledge receipt of the Notice of Privacy Practices for this office.

_____

Patient or legally authorized individual signature Date

_____

Printed name if signed on behalf of the patient Relationship to patient (Parent, guardian, representative)