Ankle & Foot Clinic of Oregon
Jerry J. Yoon, DPM, FACFAS
Diplomate, American Board of Foot and Ankle Surgery
Fellow, American College of Foot & Ankle Surgeons

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(503) 636-9656

REGISTRATION FORM

Date: _____

PATIENT INFORMATION:

Patient Name: _____
(Last name, First name, Middle Initial)

Birth date: _____ **Age**: _____

Address: _____
(City, State, Zip code)

Social Security #: _____ **Email:** _____
Please check yes or no if you would like to participate in our web portal where you can access your account thru email for personal and private documents, education information and other health information. **Y__ N__**

Sex: ___ Male ___Female **Ethnicity**: _____ (NOTE: leaving ethnicity blank will be reported as "refused to report" under your account)

Married:___ **Widowed:**___ **Single:**___ **Minor:**___ **Separated:**___ **Divorced:**___
Partnered for:____ year

Home Phone (____) _____ **Cell Phone** (____) _____

Patient Employer/School: _____ **Occupation:** _____

Employer/School Address/Phone number: _____
_____

Spouse's Name: _____ **Birth date**: _____

EMERGENCY CONTACT:

Name: _____ **Relationship:** _____

Home Phone (____) _____ **Cell Phone** (____) _____

(Continue back page)

INSURANCE INFORMATION:

___ I am a self pay patient (Please read our billing financial policy and sign)

___ I have insurance (Please provide the office with your insurance information, read our billing financial policy and sign)

ALL INSURANCE ALIGNMENT AND RELEASE – READ, SIGN, AND DATE BELOW:

I certify that I have insurance coverage with _____ and
(Name of insurance company (ies)
assign directly to Dr. Jerry Yoon, DPM all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed on this form.

X_____ Relationship to Patient: _____
(Signature of Patient, Beneficiary, Guardian or Personal Representative)

Print Name: _____ Date: _____
(Of Patient, Beneficiary, Guardian or Personal Representative)

ONLY FOR MEDICARE/MEDIGAP/MEDICAID AUTHORIZATION:

I request that payment of authorized Medicare benefits, and if applicable, Medigap/Medicaid benefits, be made either to me or on my behalf to Ankle and Foot Clinic of Oregon/Lake Oswego Foot Clinic for any services furnished to me by Dr. Jerry Yoon. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

X _____ Date: _____
(Signature of Patient, Beneficiary, Guardian or Personal Representative)

WHOM MAY WE THANK FOR REFERRING YOU? _____

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.) _____
_____

Have you ever been to a Podiatrist before? Yes___ No___
If yes, please list: _____ Last visit: _____

Is there any personal or family of diabetes? Yes___ No___
Cigarette/Tobacco use _____ Years smoked _____
Alcohol use _____ How often _____

Athletic activities in which you participate (Please list and indicate frequency) _____
_____

Please check to indicate if you have had any of the following:

Aids/HIV ___
Allergies to Anesthetics ___
Allergies to Medicine or Drugs ___
Anemia ___
Angina ___
Arthritis ___
Artificial Heart Valves of joints ___
Asthma ___
Back Problems ___
Bleeding Disorders ___
Cancer ___
Chemical Dependency ___
Chest Pain ___
Chronic Diarrhea ___
Circulatory problems ___
Diabetes ___ Type: _____
Ear Problems ___
Epilepsy ___
Eye Problems ___
Gout ___
Headaches ___
Heart Disease ___
Hepatitis or Jaundice ___
High Blood Pressure ___
Kidney Problems ___
Liver Disease ___
Low Blood Pressure ___
Neuropathy ___
Phlebitis ___
Psychiatric Care ___
Rash ___
Respiratory Disease ___
Shortness of breath ___
Sinus problems ___
Special Diet ___
Stroke ___
Tuberculosis ___
Ulcers ___
Varicose Veins ___
Weight loss ___ (unexplained)

Surgeries you have had _____

Hospitalization other than for the surgeries listed _____
_____

Family physician _____ Last visit: _____

Medications (Include prescriptions, over-the-counter medications and vitamins) _____

_____

ALLERGIES: _____

Pharmacy Name: _____ Pharmacy Number: _____

TREATMENT CONSENT:

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to examine, administer, and perform such procedures upon me as the doctor deems necessary.

X_____ Date: _____