



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



5528 SE Powell Blvd.
 Portland, OR 97206
 (503) 777-3999

543 SW Third, Suite C-1
 Lake Oswego, OR 97034
 (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 #: _____ E- mail: _____
 (Optional, necessary only for insurance purpose)

Sex: Male Female Ethnicity: _____

Married: Widowed: Single: Minor: Separated: Divorced:

Home Phone (_____) _____ Cell Phone (_____) _____

Patient Employer/School: _____ Occupation: _____

Employer/School Address/Phone number: _____

Spouse's Name: _____ Birth date: _____

Social Security #: _____ (Optional, necessary only for insurance purpose)

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)

Who is responsible for this account: _____

Subscriber Name: _____ Relationship to patient: _____

Insurance company (ies): _____

Subscriber ID #: _____ Group #: _____

Subscriber Date of Birth: _____ SS#: _____

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

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 administer and perform such procedures upon me as the doctor deems necessary.

X _____ Date: _____