Eugene Podiatry Associates
1060 Chambers
Eugene, OR 97402
Phone: (541)342-3373
Fax: (541)342-3374

Medical Questionnaire

Patient full Name _____ Date _____

Weight_____ Height_____ Shoe size_____

List the problems you are having with your feet or legs_____

_____

How long have these symptoms been present?_____

What have you done for this problem in the past?_____

Are you taking any medications?_____ If yes, please list names and dosage_____

_____

Are you allergic to any medications?_____ If yes, please list names_____

_____

Have you been hospitalized in the last 10 years?_____ If yes, please list reason(s)_____

_____

Please list all surgeries and the dates performed (as closely as possible)_____

_____

Who is your primary physician?_____

Do you have, or have you ever had and of the following? (Check if yes)

____Diabetes
____Tuberculosis
____Cancer
____High blood pressure
____Heart trouble
____Rheumatic fever
____Chest pain
____Asthma of hives
____Bleeding problems
____Arthritis
____Jaundice or hepatitis
____Loss of consciousness for any know reason
____Difficulty with anesthesia
____Recurrent infections
____Ulcers
____Blood in urine
____Blood in stool
____Chronic swelling of ankles
____Difficulty walking farther than 3 blocks
____Cramps in legs that prevent walking
____Used tobacco in the past
____Currently a tobacco user

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Patient Information Sheet

Patient full Name _____ Date _____

Address _____ Sex: Male ____ Female ____

City _____ State _____ Zip _____ Age ____ Birth Date _____

Phones _____ Occupation _____

Who may we thank for referring you to our office? _____

Insurance Policy Holder Information for Billing Purposes

Policy holder Name _____ Relationship _____

Address if different from above _____

City _____ State _____ Zip _____ Birth Date _____

Phones _____

Please Read Insurance Statement and Sign Below

Insurance policies are contracts between you, the subscriber and the insurance company. The doctor can in no way alter the contract or guarantee payment by the insurance company. You are expected to pay any copays at the time of your visit. Regardless of insurance coverage, the patient, or responsible party will be responsible for any non-covered expenses. There will be a rebilling charge on all delinquent accounts. We are set up to accept MasterCard, Visa, cash or check.

If you give permission to someone other than yourself to conduct business in our office on your behalf, please give their name and relationship to you.

Name _____ Relationship _____

I authorize my insurance benefits to be paid directly to the doctor and for him to release any medical information requested.

I also acknowledge that I was provided the opportunity to read the Notice of Privacy Practices and understood the notice.

_____ Date _____

Signature of Patient

_____

Signature of parent or guardian of minor

Rev.002

Eugene Podiatry Associates

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We make every effort to see you at your scheduled time and ask that you extend the same courtesy to us. Please arrive on time for your visit. If you arrive late, we may find it necessary to reschedule your appointment to another date and time.

Our office requires at least 24 hours notice if an appointment can not be kept. If you are unable to make your appointment, please notify us as soon as possible during regular business hours.

All missed appointments and/or late cancellations are tracked within a patient's medical record. A patient who has missed an appointment or calls with a late cancellation within a 12 month period will receive a warning letter. If you break two appointments without proper notice, we will charge a $25.00 fee.

After a third missed appointment or late cancellation we may be unable to schdule additional appointments for you.

Thank you,
Eugene Podiatry Associates

_____ _____

(signature) (date)