Account #: _____

R. Tyson Scott, DPM, FACFAS
Scott Berg, DPM, FACFAS
800 Liberty St SE | Salem, OR 97302
Phone: (503) 370-8784
Fax: (503) 362-4017

Personal Information

Patient's Full Name: _____ DOB: _____ Age: ____

Preferred Name: _____ Circle: Male / Female / Prefer not to answer

Ph #: _____ Circle: Cell / Home / Other: _____

Email Address: _____

Mailing Address: _____

City / State / Zip Code: _____

Employer: _____ City & State: _____

Emergency Contact: _____ Relationship: _____ Ph #: _____

****Guarantor (Person financially responsible AFTER insurance is billed):**

Name: _____ DOB: _____ Ph #: _____

Relationship to Patient (only fill out if patient is not their own guarantor): _____

Insurance Information

**** (Insurance information is REQUIRED to be filled out) ****

*Name of **Primary** Insurance: _____ *Member ID #: _____

*Name & DOB of Subscriber: _____ *Relation to Subscriber: _____

*Name of **Secondary** Insurance: _____*Member ID #: _____

*Name & DOB of Subscriber: _____ *Relation to Subscriber: _____

Name of **Tertiary** Insurance: _____ Member ID #: _____

Name & DOB of Subscriber: _____ Relation to Subscriber: _____

**SSN (for Medicare & VA patients): _____

Continuity of Care

Please provide fist and last names

Primary Care Physician: _____

Clinic Name: _____Ph #: _____

Specialty Care Physician: _____ Reason: _____

Preferred Pharmacy (including location): _____

Health History

WEIGHT: _____ HEIGHT: _____ SHOE SIZE: _____

Please list any serious health/medical conditions/hospitalizations/surgeries that have occurred in the past 3 years including dates (if possible):

_____

_____

_____

ALL QUESTIONS MUST BE ANSWERED FOR INSURANCE PURPOSES

Do have an Advanced Directive? Yes / No Are you diabetic? Yes / No → if yes, A1C: _____ Type I / Type II

Do you smoke tobacco? Yes / No → if yes, how many cigarettes per day? _____ Do you chew tobacco? Yes / No

Are you a previous smoker? Yes / No Do you drink alcohol? Yes / No → if yes, how often? Rarely / Moderately / Daily / Quit

Have you fallen within the last year? Yes / No → If yes, how many times? Once / More than once Were you injured? Yes / No

Allergies:

Please circle if you are allergic to the following:

Penicillin / Aspirin / Iodine / Latex / Sulfa / Local Anesthetics / Adhesive Tape Other: _____

Medications:

Please list all CURRENT medications (including prescribed, supplements & over the counter medications)

☐ Please check mark if a medication list was provided to a receptionist @ check in

Medication Name / Dosage / Frequency:

_____

_____

_____

Family History:

Please circle if any of your blood relatives & relationship if they have had any of the following

Diabetes	_____	Heart Troubles	_____	Unknown Family History
High Blood Pressure	_____	Birth Abnormalities	_____	
Arthritis	_____	Cancer	_____	

Agreements

Workers Compensation & Motor Vehicle Accidents

_____ **(Initial)** At Coastline Foot and Ankle Center, we DO NOT attend patients with workers compensation and/or motor vehicle accidents claims. Please initial acknowledging that the patient's visit is not related to a worker's injury or a motor vehicle accident.

Release of Benefits and Information

_____ **(Initial)** Release of Benefits and Information: I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. I understand that I am requesting services that may not be a covered benefit with my insurance carrier and I agree to pay for these services personally if necessary. I agree to any co-pays due at the time service is rendered. I authorize the doctor or insurance company to release any information required to assist in the collection of monies due, and I authorize payment to be paid directly to this office. If it becomes necessary to seek third party services for collection of monies owed, I agree to pay for all costs and expenses, including reasonable attorney fees and court cost.

Financial Policy

_____ **(Initial)** Patient is aware that they are financially responsible for any outstanding statements on their account at Coastline Foot and Ankle Center. If patient is not their own guarantor, the guarantor will be financially responsible for any account balance the patient may have on their account. Patient acknowledges and agrees to Coastline Foot & Ankle's full financial policy and understand that Coastline requires deposits for orthotics, deposits for outpatient surgeries, they have no show/same day cancellation fees, and copays are due at the time of appointment if a copay is applied by their insurance. Patient agrees to pay anything out of pocket if their insurance does not cover treatment. If the patient is a self-pay patient, they agree to pay in full for their visit at time of the appointment. Patient may ask for a copy of our financial policy.

HIPAA Consent

_____ **(Initial)** The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides privacy protections to your medical records. Our benefits office (or other third party designated by our office) may sometimes need to disclose medical information or payment information protected by HIPAA in relation to our group health plans to your family members or close friends involved in your health care. For example, your spouse may need to contact us if you are in the hospital to determine whether a particular procedure is covered under our group health plan or may need assistance filing a claim for medical services. Under HIPAA, unless you specifically object, we are allowed to use our professional judgment in deciding whether to discuss your medical and payment information with your family members or close friends. However, we would like to provide you with the opportunity to tell us with whom we may discuss your medical or payment information under our group health plans.
You may communicate with the following individual(s) relating to my medical or payment information:

Name:_____ Relation: _____

Name:_____ Relation: _____

Name:_____ Relation: _____

Print Patient Name: _____ Date: _____

Patient Signature (Guarantor if patient is a minor): _____