LAKE OSWEGO FOOT CLINIC
Jerry J. Yoon D.P.M.
Diplomate, American Board of Foot and Ankle surgery
Fellow, American College of Foot & Ankle Surgeons

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REGISTRATION FORM

Date: _____

PATIENT INFORMATION:

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

Birth date: _____ **Age**: _____

Address: _____
(City, State, Zip code)

Social Security #: _____(optional) **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)

PATIENT NAME: _____ DATE: _____

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? _____

PATIENT NAME: _____DATE: _____

PODIATRIC HISTORY

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

_____

Have you ever been to a podiatrist before? Yes_____ No _____ If yes, date: _____

Do you have diabetes or is there family history of diabetes? _____

Cigarette/Tobacco use: Yes_____ No _____ If yes, how many years smoked: _____

Alcohol use: Yes_____ No _____ If yes, how often? _____

Athletic activities in which you participate in, (please list and indicate frequency)

_____

List any medical problems that other doctors have diagnosed:

_____

_____

_____

Surgeries you have had: _____

_____

Hospitalization other than for the surgeries listed above: _____

_____

Medications, (Please include prescriptions, over the counter and vitamins):

_____

_____

_____

Allergies: _____

_____

Primary physician:_____ Last visit: _____

Pharmacy Name & City: _____

TREATMENT CONSENT:

I hereby consent and give my permission to the doctor to examine me and perform such procedures upon me as the doctor deems medically necessary after it has been explained to me.

PATIENT'S SIGNATURE: _____ DATE: _____