Kessa Mauras DPM
1100 E. Marina Way Ste 223
Hood River, OR, 97031
Telephone: 541-386-1006
Fax: 541-386-1284

NAME: ______________________________ Date of Birth: ___/___/___ Age: _____ Sex: M F

Mailing Address: ______________________________ City: ____________________ State: ____ Zip __________

May We Leave A Message?

Home Phone #: ______________________________ Yes No
Work Phone #: ______________________________ Yes No
Cell Phone #: ______________________________ Yes No
E-Mail: ______________________________ Yes No

Primary Language: ____________________

How Did You Hear About Us? Referred by Physician □ Internet □ Phone Book □ Other □ ____________________

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY: YES NO
If Yes, Name: ______________________________ Relationship: ____________________ Phone #: ______________

EMERGENCY CONTACT: ______________________________ Relationship: ____________________ Phone #: ______________

PRIMARY CARE DOCTOR: ____________________________ Who referred you to us? ______________________________
PHARMACY: ____________________________________ LOCATION: ______________________ PHONE #: ______________

WHO IS RESPONSIBLE FOR PAYMENT? ____________________________________ Relationship to Patient: ______________
Address: ______________________ City/State ______________________ Zip Code: ___________ Phone#: ______________

INSURANCE: YOU WILL BE ASKED FOR YOUR INSURANCE CARD AT THE TIME OF YOUR VISIT

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTION, OVER-THE-COUNTER AND HERBAL SUPPLEMENTS) Write on the back of this sheet if additional space is needed.

MEDICATION	DOSE	HOW OFTEN	FOR TREATMENT OF:

ALLERGIES: ☐ None Known ☐ Anesthesia ☐ Tape ☐ Latex ☐ Shellfish ☐ Iodine ☐ Foods

☐ Medication Allergies: ____

PLEASE LIST ALL PRIOR SURGERIES:

Type of Surgery Date Type of Surgery Date

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

PLEASE LIST ALL PRIOR HOSPITALIZATION (Other than for surgery):

Reason for hospitalization Date Reason for hospitalization Date

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

SOCIAL HISTORY:

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE ☐ CURRENT USE – TYPE ____________________ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? ________ ☐ SMOKE ___ PACKS/DAY FOR _____ YEARS
☐ CHEW – HOW MUCH? ____________

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? ______ TYPE: ________________ ☐ CURRENT USE – TYPE ____________
☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: ____________________ OCCUPATION: ____________________
How much are you on your feet at work? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE: ☐ Children-Age(s) ____ ☐ Pet(s) What Kind? ________________
☐ Elderly or disabled family member ☐ Other ____________________

EXERCISE: ☐ Never ☐ Rare ☐ Occasional ☐ Weekly ☐ Several times per week ☐ Daily

Types of Exercise: ____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N		FIBROMYALGIA	Y	N		NEUROPATHY	Y	N
ANEMIA	Y	N		GOUT	Y	N		OPEN SORES	Y	N
ARTHRITIS	Y	N		HEART ATTACK	Y	N		PNEUMONIA	Y	N
ASTHMA	Y	N		HEART DISEASE/FAILURE	Y	N		POLIO	Y	N
BACK TROUBLE	Y	N		HEPATITIS	Y	N		RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N		HIV+/AIDS	Y	N		SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N		HIGH BLOOD PRESSURE	Y	N		SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N		KIDNEY DISEASE	Y	N		SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N		LIVER DISEASE	Y	N		STOMACH ULCERS	Y	N
BRONCHRITIS/EMPHYSEMA	Y	N		LOW BLOOD PRESSURE	Y	N		STROKE	Y	N
CANCER	Y	N		MIGRAINE HEADACHES	Y	N		THYROID DISEASE	Y	N
DIABETES	Y	N		MITRAL VALVE PROLAPSE	Y	N		TUBERCULOSIS	Y	N

OTHER CONDITION: ____

FAMILY HISTORY: Do you have a family history of: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE
☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE
☐ RHEUMATOID ARTHRITIS ☐ OTHER ____________________

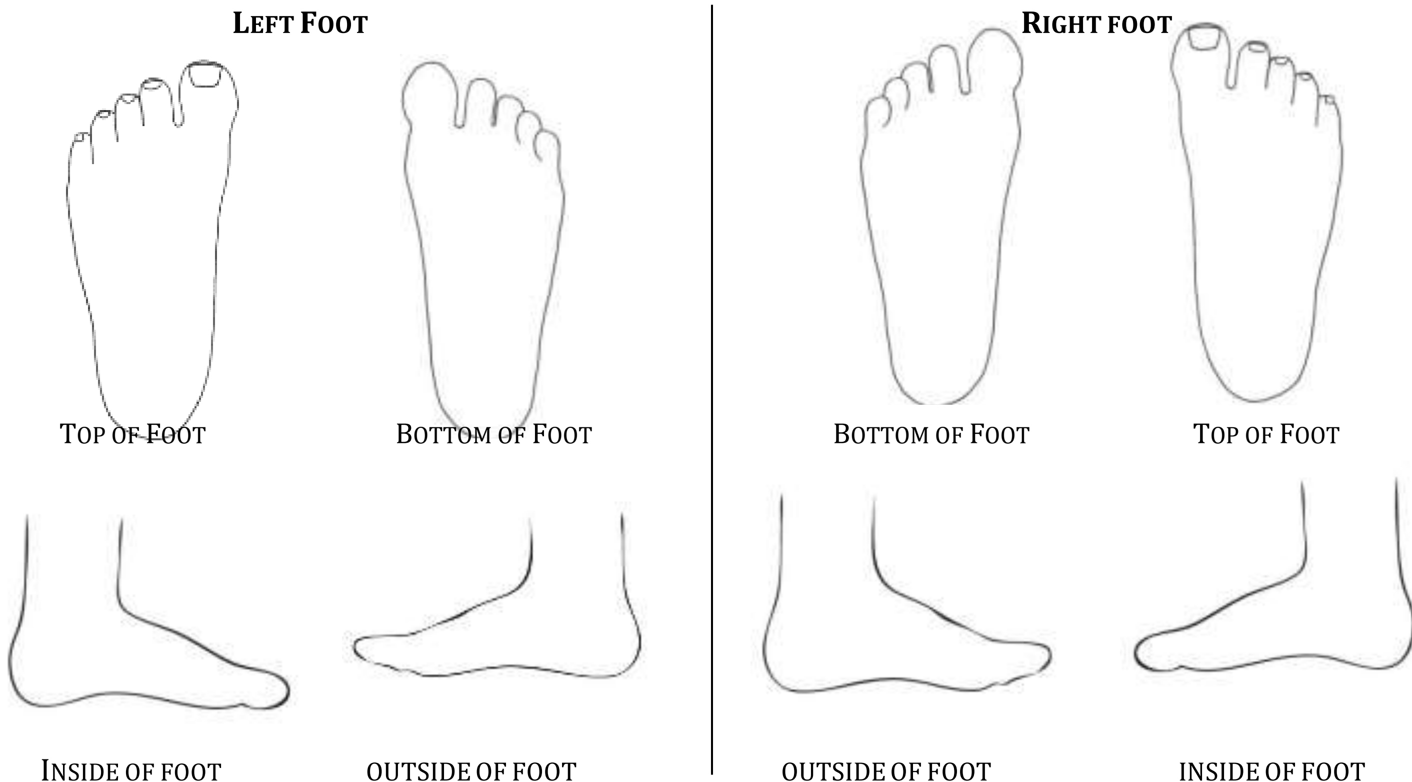
HEIGHT _______ WEIGHT _______ SHOE SIZE _______

<u>CURRENT PROBLEM:</u>

What specific problem brings you to our office today? ____

____

Where is the pain/problem located? Please mark on the pictures below.



To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

____ ________________________________

Print Name of patient, parent or guardian Signature of Doctor

____ ________________

If other than patient, relationship to patient Date

____ ________________

Signature Date

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Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.

- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.

- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.

- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.

- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.

- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.

- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: ____

Printed Name of Patient/Responsible Party ___________________________________ Date: ____________

________ Patient initials to indicate copy received.

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided the opportunity to read the Notice of Privacy Practices and that I understand this Notice

Printed Name Date

Signature Date of Birth

Information regarding my medical condition(s) may be released to:

Name _____________________ Relationship _____________________

A COPY OF OUR PRIVACY POLICY IS AVAILABLE ON OUR WEBSITE AT:

www.mthoodpodiatry.com

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained for one of the following reasons:

☐ Individual refused to sign
☐ Communication barriers prohibited obtaining the acknowledgment
☐ An emergency situation prevented us from obtaining acknowledgment
☐ Other ____