McMinnville Foot & Ankle Associates, LLC
Matthew W.E. Lewin, DPM, DABPM

Patient Information

Name (first) _____ (middle) _____ (last) _____
SSN _____ Date of birth _____ Age _____ Gender _____
Mailing Address _____ City/State/Zip _____
Home phone _____ Work phone _____ Cell Phone _____
Preferred phone ☐ Home ☐ Work ☐ Cell Email Address _____
Race/Ethnicity ☐ African American ☐ Caucasian ☐ American Indian ☐ Hispanic ☐ Asian ☐ Other _____
Preferred Language _____ Marital Status _____
Employer _____ Primary Care _____
Preferred Pharmacy _____ Location _____

PERSON RESPONSIBLE FOR BILL (if other than the patient or if the patient is a minor)

Name (first) _____ (middle) _____ (last) _____
SSN _____ Date of birth _____ Gender _____
Mailing Address _____ City/State/Zip _____
Home phone _____ Work _____ Cell _____
Care Home Facility _____ Contact _____

MEDICAL INSURANCE INFORMATION

Primary Insurance _____ Policyholder Name _____
Policyholder birth date _____ Relation to Patient _____
ID# _____ Group # _____
Secondary Insurance _____ Policyholder Name _____
Policyholder birth date _____ Relation to Patient _____
ID# _____ Group # _____
Is this visit due to: ☐ **work-related accident** ☐ **automobile accident** Date of injury _____
Claim # _____ Insurance Company _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____ Phone _____

CONSENT AND AUTHORIZATIONS

I certify that the medical information given is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my condition. If I have (or my dependent has) insurance coverage I assign directly to McMinnville Foot & Ankle Associates, LLC, all insurance benefits or Medicare benefits for the services rendered. I understand I am financially responsible for all charges, whether paid by insurance or not. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient / Representative Signature _____ Date _____

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Patient Medical History

Name (first) _____ (middle) _____ (last) _____

Current height _____ Weight _____ Shoe size _____

Current Medications _____

_____

_____

Allergies to medications _____

Other allergies _____ ☐ Latex ☐ Tape ☐ Betadine (iodine)

REASON FOR THIS VISIT **Rate your pain level 1-10** _____

Describe your foot/ankle problem _____

☐ Right ☐ Left How long has it been bothering you? Days _____ Weeks _____ Months _____ Years _____

Indicate past problems of your feet and ankles _____

Bunions	Flat Feet	Gout	Neuromas	Plantar Fasciitis
Circulation	Foot Ulcer	Hammertoes	Peripheral Neuropathy	Warts
Corns & Calluses	Ganglions	Ingrown Nails	Peripheral Vascular Disease	

PAST SURGICAL procedures on your feet or ankles _____

_____

Other major surgeries: _____

_____

MEDICAL HISTORY

Do you have Diabetes? ☐ Yes ☐ No ☐ Type 1 ☐ Type 2 ☐ Gestational For how long? _____

Circle any you have had: Last A1C? _____

Anemia	Hearing Difficulty	Lung Condition	Stomach Ulcers
Arthritis	High Blood Pressure	Pacemaker	Tuberculosis
Asthma	Heart Valve Implant	Rheumatic Fever	Thyroid
Frequent Infections	High Cholesterol	Stroke	Vision Problems

Heart Problems -Explain: _____ Artificial Joints -Where: _____

SOCIAL HISTORY

Tobacco use: ☐ Current ☐ Past ☐ Never Medical Marijuana Use: Y / N

Type _____ Number of packs per day _____ for _____ years

Alcohol use: ☐ Current ☐ Past ☐ Never Frequency _____

Physical Activity: How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days? _____

On days that you engage in moderate to strenuous exercise, how many minutes, on average, do you exercise? _____

FAMILY HISTORY

Circle blood relative history of:

Arthritis	Bleeding Disorder	Diabetes	Heart Disease
Blood Clots	Circulation Problems	Flat Feet / Bunions	Stroke

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Welcome to McMinnville Foot & Ankle Associates, LLC

This form should help you clearly understand our financial policy and HIPAA policies. If you have any questions, please do not hesitate to ask.

• The Notice of Privacy Practices provides information about how we may use and disclose protected health information about you, you may request a copy.
• I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.
• I consent to give McMinnville Foot & Ankle Associates permission to retrieve prescription history from my pharmacy.
• If you do not have medical insurance or if the deductible of your insurance policy has not been met, full payment is expected on the day of service. Payment options are cash, check, card, and money order.
• Co-pays must be paid at each visit per your insurance contract and as required by law.
• It is your responsibility to know your insurance plan and what is covered and what is not**.**
• If payment has not been made for 60 days, once the balance becomes your responsibility, the account may be assessed with a $5 late fee per month. Delinquent accounts, over 120 days will be turned over to an outside collection agency. An additional $75 service fee will be added to the outstanding balance.
• For worker's compensation cases or motor vehicle accidents, we will bill the appropriate insurance. If your claim is denied, you will be responsible for payment in full.
• If you are being treated as part of a personal injury lawsuit or claim, payment of the bill remains your responsibility. We cannot bill your attorney for charges incurred due to your personal injury.
• By signing this form, you are giving McMinnville Foot & Ankle Associates, LLC authority to release any information required to complete your insurance claim. The authorization will be effective until you choose to revoke it in writing. By signing this form, you understand this policy and are bound by it.
• By providing an email or phone number to receive text messages, I consent to receiving appointment reminders and other healthcare communications/information at the email and text address from McMinnville Foot & Ankle Associates, LLC.

No Show & Cancellation Policy

Please note that any patient arriving more than 10 minutes late to their scheduled appointment may be rescheduled to accommodate the needs of those who have arrived on time for their appointments. Cancellations must occur prior to 24 hours of the appointment so it can be given to someone else in need. Cancellations with less than 24-hour notice will result in a $40 no show fee.

How would you prefer to be reminded of upcoming appointments:

Call or Text _____ Email _____

Print Name _____ DOB: _____

Patient / Representative Signature _____ Date: _____