Steven G. Tillett, D.P.M.

6274 SW Capitol Hwy
Portland, Oregon 97239

Welcome to our Clinic! Our goal is to provide you with the highest quality medical care available. Please **bring the completed enclosed paperwork** along with your **insurance card and legal picture ID** to your appointment. To protect your identity we will be taking a photo copy of your ID for your chart. **Also, remember to bring any imaging or medical reports regarding your condition, as we will be unable to see you without them**. **Please allow 10-15 minutes for parking.**

You are responsible for securing referrals from your Primary Care Physician if required by your insurance. If a referral is required and not in place at the time of your appointment it will be necessary to reschedule.

How to find us: We are on Beaverton-Hillsdale Highway, (directly across from the "76" Gas Station), directly next door to the "Hillsdale Pharmacy" (Bowman's) and the Dance Studio. Also, Right next to the entrance to the **Wilson High School** Stadium.

We are 1/4 (0.25) mile from Terwilliger Blvd, at the Sunset Blvd intersection (Next to the Wilson High School Stadium entrance).

From Portland: **Barbur Blvd South** for 3.0 miles, Take **Exit** to **OR-10 W** (Capitol Hwy), continue **up hill** to, Turn **LEFT** at the **Hillsdale Pharmacy** (we share a parking lot) - just passed the **Sunset Blvd** (2nd Lighted) intersection**.** Across from the **76 gas station**

From Beaverton: Beaverton-Hillsdale Hwy head **EAST** for 4.7 miles, Continue straight to stay on OR-10 E (Capitol Hwy). Continue into Hillsdale, Left-ish into **Hillsdale**, then: Take a **RIGHT** between our office and the **"Hillsdale Pharmacy" -** just before the entry to the **Wilson High School stadium**.

From South: I-5 North, take **Exit 297** for **Terwilliger** Blvd, Turn **LEFT onto Terwilliger Blvd**, Continue for **1 mile**, Then turn **LEFT** onto **Hwy-10 W**, Head **up hill** for **1/2** (0.5) **mile**, Turn **LEFT** at the Hillsdale Pharmacy (we share a parking lot) - just passed the **Sunset Blvd** (2nd Lighted) intersection. Across from the **76 gas station**.
*We look forward to seeing you.

OFFICE HOURS:
Mon-Fri 8:00- 5:00

We are closed from 12-1

PODIATRIC REGISTRATION AND HISTORY

PATIENT INFORMATION

Date _____

Patient Name _____

Address _____

_____

City State Zip

Sex: ☐M ☐F Age _____ Birth Date _____

SS# _____

Occupation/Employer _____

Employer _____

Work Address _____

☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

Spouse (Partner)'s Name _____

Birth Date _____ SS# _____

Occupation/Employer _____

Did another physician refer you to our office?

☐ Yes ☐ No, Their name _____

Who referred you? _____

Who is your Primary Care Dr? _____

PHONE NUMBER

Home: _____ Cell _____

Work_____

Best time & place to reach you _____

*__Appointment reminder contact info:__

☐TEXT message to: _____

☐Phone Call ☐E-mail to: _____

E-mail only used for YOU to gain access to your MEDICAL RECORDS

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home phone _____ Work _____

INSURANCE

Who is responsible for this account? _____

Relationship to patient _____

Insurance Co. _____

Policy # _____ Group # _____

Supplemental Insurance Company _____

Subscriber Name _____

Birth Date _____ SS# _____

Relationship to patient _____

Policy Dates From _____ to _____

Policy # _____Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Steve Tillett all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Responsible Party Signature Date

_____ _____

Relationship Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Steve Tillett for any services furnished me by that physician. I authorize any holder of medical information about me, to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Beneficiary Signature Date

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated?

_____

_____

_____

_____

_____

Have you ever been seen by a Foot Specialist before? ☐ Yes ☐ No

If yes, please list:

Name _____

Last visit _____

Shoe Size _____

Weight _____ Height: _____

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

_____

_____

_____

_____

_____

Is there a personal or family history of Diabetes? ☐ Yes ☐ No

GOVERNMENT MANDATED QUESTIONS

ETHNICITY:

☐non-Hispanic ☐Hispanic ☐Not specified

Preferred Language _____

Race _____

E-mail: _____

E-mail is ONLY used for YOU to gain access to your MEDICAL RECORDS

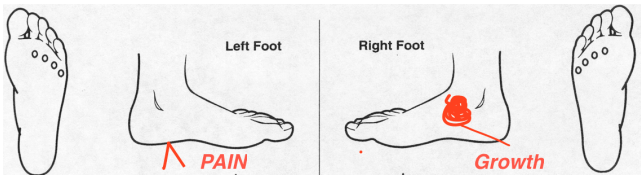
OFFICE USE ONLY:

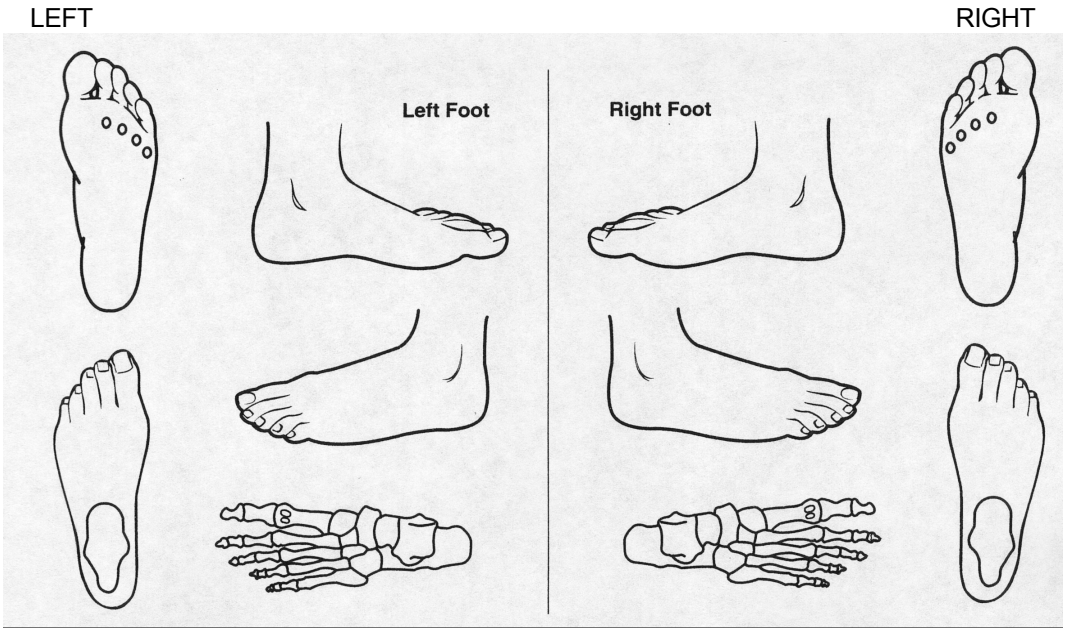
☐PMHx ☐Meds ☐Allergies

☐PSHx ☐Dx ☐Tobacco

☐PHR Access Completed

MARK AREAS OF PAIN, and or OF CONCERN

EXAMPLE:	



By signing this consent form I acknowledge that I have read, understand and voluntarily consent to and authorize the following:

Guarantee of Payment: I authorize Dr. Steve Tillett (Ankle and Foot Centers, LLC) to release to my insurance company any information concerning my medical care in order to process my claim. I also assign medical payments from my insurance company to Dr. Steve Tillett (Ankle and Foot Centers, LLC), I understand that I am personally responsible for all charges from Dr. Steve Tillett (Ankle and Foot Centers, LLC) whether paid for or not and guarantee payment of the bill.

Release of Medical Records: I authorize Dr. Steve Tillett (Ankle and Foot Centers, LLC) to use and disclose verbally, electronically and/or in writing health information about me for purposes of treatment to ensure continuity of care and payment of charges. I understand that I have the right to ask that some or all of my health information not be used or disclosed.

Receipt of Privacy Practices: By signing this form I acknowledge that a copy of the Notice of Privacy Practices which describes how Dr. Steve Tillett (Ankle and Foot Centers, LLC) will handle health information about me is available upon request.

Patient (or guardian) signature _____ Date _____

PODIATRIC REGISTRATION AND HISTORY

MEDICAL HISTORY

Other Medical Problems:

Please List Surgeries & Hospitalizations you have had (include approximate year):

☐ I have **NOT** had Surgery before ☐ *I have **NOT** had complications with Anesthesia from previous surgeries*

Type of Surgery	~ Year	Type of Surgery	~ Year

SPECIAL DIET ☐ No ☐ Yes (kind: _____)

Family physician _____Date of last visit _____

Are you now or have you been, under any other doctor's care for any reason over the past two years? ☐ Yes ☐ No

If yes, please explain _____

_____

_____

_____

_____

_____

_____

_____

_____

Is there any chance that you could be pregnant now? ☐ Yes ☐ No

Tobacco Use: ☐ Never ☐ Cigarettes Quit Date _____ ***Current Smoker**:* Packs/day?_____ # of years? _____

→ Other Tobacco: ☐ Pipe ☐ Cigar ☐ Chew

Alcohol use: ☐ No ☐ Yes → If yes then, average (Ballpark – not just at the Ballpark) # of Drinks per week of:

beer _____ wine _____ hard alcohol _____

SOBER (prior issues with alcohol - C&S #_____ mo's / yrs Drugs Clean Date _____

MEDICATIONS

Do you take oral contraceptives? ☐ Yes ☐ No

LIST prescriptions, over-the-counter medications and vitamins:

MMedicine & Dose	Medicine & Dose

Pharmacy Name(s) _____

Pharmacy Phone(s) _____

ALLERGIES TO MEDICINES

☐ **I have NO Allergies to medicines**

ALLERGEN: -when was this discovered, as a: Child, Teen or Adult					**DESCRIBE REACTION**
EXAMPLE ☑ Penicillin ☑ Teen					e.g., Rash,Cough, diff. Breathing,
	DISCOVERED				Mental Status Change or Anaphylaxis
☐ Penicillin	*Discovered as:*	☐ Child	☐ Teen	☐ Adult	
☐ Sulfa	*Discovered as:*	☐ Child	☐ Teen	☐ Adult	
☐ Iodine	*Discovered as:*	☐ Child	☐ Teen	☐ Adult	
☐ Seafood	*Discovered as:*	☐ Child	☐ Teen	☐ Adult	
☐ Local Aneshetic (Novocaine)	*Discovered as*	☐ Child	☐ Teen	☐ Adult	
☐ Codeine	*Discovered as:*	☐ Child	☐ Teen	☐ Adult	
☐ Aspirin	*Discovered as:*	☐ Child	☐ Teen	☐ Adult	
☐ Demerol	*Discovered as:*	☐ Child	☐ Teen	☐ Adult	
☐ Adhesive Tape	*Discovered as:*	☐ Child	☐ Teen	☐ Adult	
☐ OTHERS – LIST:					

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet, or medical conditions affecting my feet.

Patient (or guardian) signature _____ Date _____

REVIEWW OFF SYSTEMS / PAST MEDICAL HISTORY

Mark any of the following that you have:

GENERAL
- ☐ Tire easily
- ☐ Marked weight change
- ☐ Night sweats
- ☐ Persistent Fever
- ☐ Sensitivity to heat or cold

SKIN
- ☐ Rashes
- ☐ Change in hair or nails

EYES
- ☐ Change in vision

Ears
- ☐ Change in hearing
- ☐ Ringing in ears
- ☐ Discharge

NOSE
- ☐ Change of smell
- ☐ Obstruction
- ☐ Excessive discharge
- ☐ Bleeding
- ☐ Sinus infections

MOUTH / THROAT
- ☐ Sore gums or tongue
- ☐ Lumps or Ulcers
- ☐ Soreness
- ☐ Hoarseness

HEART & LUNGS
- ☐ Cough-persistent
- ☐ Yellow or green sputum
- ☐ Bloody sputum
- ☐ Wheezing
- ☐ Chest pain / tightness
- ☐ Difficulty breathing when laying down
- ☐ Swelling of ankle
- ☐ Palpitations

DIGESTIVE
- ☐ Change in appetite
- ☐ Difficulty swallowing
- ☐ Heart burn
- ☐ Nausea
- ☐ Vomiting
- ☐ Change in stools
- ☐ Jaundice

ENDOCRINE
- ☐ Thyroid trouble
- ☐ Adrenal trouble
- ☐ Cortisone treatments
- ☐ Are you nursing and a baby?

GENITOURINARY
- ☐ Increased frequency of urination
- ☐ Night-time urination
- ☐ Could you be pregnant?

LOCOMOTOR
- ☐ Muscle cramps
- ☐ Pain in the joints
- ☐ Swelling in the joints
- ☐ Stiffness

NERVOUS SYSTEM
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Memory loss
- ☐ Convulsions
- ☐ Muscle weakness or paralysis

Mark "Yes" to indicate if you are currently or have ever had any of the following:

SYSTEMIC

AIDS/HIV (042) ☐ Yes
ALZHEIMER'S DISEASE (331.0) ☐ Yes
ALCOHOL ABUSE HISTORY (305.00) ☐ Yes
→ DRUG ABUSE HISTORY (305.90) ☐ Yes
→ CLEAN/SOBER HOW LONG: _____
ARTIFICIAL JOINTS ☐ Yes
GOUT (274.00) ☐ Yes
OSTEOPOROSIS ☐ Yes
LIVER DISEASE (HEPATITIS) (070.9) ☐ Yes
→ TYPE : _____
→ CIRRHOSIS OF LIVER (571.5) ☐ Yes
HIGH CHOLESTEROL (272.4) ☐ Yes
KIDNEY PROBLEMS ☐ Yes
→ KIDNEY FAILURE (586) ☐ Yes

PSYCHOLOGICAL/PSYCHIATRIC

ANXIETY (300.09) /DEPRESSION (311) ☐ Yes
→ HISTORY OF PSYCHIATRIC CARE ☐ Yes
→ WHICH: _____
LEARNING DISORDERS ☐ Yes

BLEEDING / CIRCULATION DISORDER

→ SICKLE CELL DISEASE (282.60) ☐ Yes
→ PHLEBITIS (451.9) ☐ Yes
→ BLOOD CLOTS (DVT'S) (453.40) ☐ Yes
→ SWELLING - ANKLES/FEET(457.1) ☐ Yes
→ VARICOSE VEINS (454) ☐ Yes
→ OTHER - Explain:
FOOT OR LEG CRAMPS ☐ Yes

CANCER ☐ Yes
- ☐ COLON CA
- ☐ CERVICAL CA
- ☐ BREAST CA
- ☐ OVARIAN CA
- ☐ SKIN CA

→ OTHER - What kind:

→ When: _____

→ are you still being Treated: ☐ Yes

BOWEL ISSUES

COLITIS (556.9) ☐ Yes
CHRONIC DIARRHEA (787.91) ☐ Yes
CHRON'S DISEASE (555.9) ☐ Yes
STOMACH ULCERS (531.91) ☐ Yes

LUNG DISEASE

ASTHMA (493.9) ☐ Yes
COPD (496) ☐ Yes
EMPHYSEMA (492.8) ☐ Yes
TUBERCULOSIS (010.80) ☐ Yes

NERVOUS SYSTEM

STROKE (434.91) – WHEN: _____ ☐ Yes
EPILEPSY (345.9) ☐ Yes
GLAUCOMA (365.9) ☐ Yes
HEADACHES, FREQUENT ☐ Yes
HEADACHES, MIGRAINES ☐ Yes
SEIZURES (345.90) ☐ Yes
SLEEP DISORDERS (327.0) ☐ Yes
SLEEP APNEA (327.29) ☐ Yes

HEART DISEASE

HEART ATTACK (when:_____) ☐ Yes
→ Arrhythmia ☐ Yes
→ Artificial Heart valves ☐ Yes
→ Chest Pain (Angina) ☐ Yes
→ CHF (428.0) ☐ Yes
→ High Blood Pressure (401.9) ☐ Yes
→ Heart Attack (MI) (429.79) ☐ Yes
→ Mitral Valve Prolapse (424.0) ☐ Yes
→ Murmur (785.2) ☐ Yes
→ PACEMAKER (V45.01) ☐ Yes
→ STROKE – NO AFFECT (V12.54) ☐ Yes
→ STROKE WITH AFFECT (438.89) ☐ Yes
(when:_____)

EXPLAIN:

OTHER

BACK PROBLEMS ☐ Yes
CORTISONE TREATMENTS ☐ Yes
EYE PROBLEMS ☐ Yes
RHEUMATIC ARTHRITIS (714.0) ☐ Yes
SERIOUS INJURY ☐ Yes
THYROID DISEASE ☐ Yes
VENEREAL DISEASE ☐ Yes

EXPLAIN:

DIABETES (250.0X) ☐ Yes
→ X = INSULIN: 1 NON-INSULIN: 2
→ USE INSULIN ☐ Yes (250.01) ☐ No (250.00)

*ANSWER THE FOLLOWING IF YOU KNOW:

DM WITH NEUROPATHY (250.6X) ☐ Yes
→ USE INSULIN ☐ Yes (250.61) ☐ No (250.60)

DM WITH PVD (250.7X) ☐ Yes
→ USE INSULIN ☐ Yes (250.71) ☐ No (250.70)

FOOT ULCERS (707.X) ☐ Yes
→ X = MIDFOOT / HEEL: 4 FOREFOOT: 5