PATIENT INFORMATION

G. Jason Wilks, DPM, P.C.
Wilks Advanced Foot Care

Patient Name: ____ Male Female
First Name MI Last Name
Preferred Name: ______________________

Date of Birth: ______________________ **Social Security** #: ______________________

Marital Status (check one): Single Married Divorced Separated Widowed

Mailing Address: ______________________________ **City/St/Zip** ______________________
Physical Address: ______________________________ City/St/Zip ______________________

Home Phone#: (__)____________ **Cell Phone#:** (__)____________ **Work Phone#:** (__)____________

Preferred communication: home phone, cell, work #, text, none

Email address: ____

Name of Primary Care Provider: ____

Pharmacy: ____

Employer: ______________________________ Occupation: ______________________

Spouse: ______________________ **DOB**: ____________ **Social Security**#: ______________
Spouse Address: ______________________________ City/St/Zip ______________________
Spouse Employer: ______________________________ Work Phone#: (__)____________

If someone other than the PATIENT is responsible for payment, complete the following:
Name of responsible party: ______________________________ Relationship to patient: ______________
Address: ______________________________ City/St/Zip ______________________
Home Phone#: (__)____________ Cell Phone#: (__)____________ Work Phone#: (__)____________
Birthdate: ____________ Social Security#: ______________ Employer: ______________________

How do you intend to pay? Cash Check Visa/MasterCard Insurance Other

Primary Insurance: ______________________________ Phone#: (__)____________
Name of Insured: ______________________ DOB: ____________ SSN: ______________
Policy #: ______________________ Group#: ______________________
Address: ______________________________ City/St/Zip ______________________

Secondary Insurance:______________________________Phone#: (__)____________
Name of Insured: ______________________ DOB: ____________ SSN: ______________
Policy #: ______________________ Group#: ______________________
Address: ______________________________ City/St/Zip ______________________

Patient Signature: ______________________________ Date: ______________________

G. JASON WILKS, DPM, PC
WILKS ADVANCED FOOT CARE

PATIENT AUTHORIZATION TO LEAVE MESSAGES ON ANSWERING MACHINE/VOICEMAIL AND/OR WITH FAMILY MEMBERS AND FRIENDS AND TO DISCLOSE HEALTH INFORMATION TO FAMILY MEMBERS AND FRIENDS.

Patient Name: ____ Date of Birth: ______________________

I hereby authorize all of G. Jason Wilks, DPM, PC/Wilks Advanced Foot Care, office staff, healthcare providers, and any agents or independent contractors acting at and under the direction of same to leave a message regarding appointment reminders, test results, or diagnostic results with a designated family member and /or on my answering/voicemail and to disclose any health information to designated family members.

Authorization to leave message on **answering machine/voicemail:** Yes No (Please Circle one)
Authorization to use **text** for provider review Yes No (Please Circle one)
Authorization to use **email** for provider review and to receive medical educational information Yes No (Please Circle one)

Authorization to **leave message** with designated names listed below:

Name	Relationship	Phone/Cell

Authorization to **discuss all health information** with designated names listed below:

Name	Relationship	Phone/Cell

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM

I have received a copy of G. Jason Wilks, DPM, PC's/Wilks Advanced Foot Care Notice of Privacy Practices.

____ ______________________
Signature **Date**

If you are signing as the patient's guardian or legal power of attorney (documentation required):

____ ______________________
Print Name Describe Authority

WILKS ADVANCED FOOT CARE
G. JASON WILKS, DPM, PC

Patient Name ____ **DOB:** _______________________

Please provide the additional information which is required for federal standards. All information provided on this form will be kept confidential.

1. **Primary Language** (i.e. English, Spanish, Sign Language, etc.) _______________________

2. **Race** (Check appropriate box)

☐ Asian
☐ Chinese
☐ Filipino
☐ Japanese
☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander
☐ Patient Declined
☐ State Prohibited
☐ Multiracial
☐ Other
☐ Undetermined

3. **Ethnicity**
Do you consider yourself to be Hispanic or Latino according to the definitions below? (Choose only one)

☐ Hispanic or Latino/Spanish
☐ Non Hispanic or Latino
☐ Patient Declined
☐ State Prohibited

☐ **DECLINE: By checking this box, I hereby decline to provide the above information.**

____ _____________________
Patient Signature or Patient Representative Signature **Date**

____
Print Name (if signing on patient's behalf (Power of Attorney paperwork must be provided)

G. Jason Wilks, DPM, PC
Wilks Advanced Foot Care

OFFICE AND FINANCIAL POLICY

G. Jason Wilks, DPM, PC/Wilks Advanced Foot Care would like to inform you of our office and financial policies. Please do not hesitate to ask for further explanation if there is anything you do not understand.

Registration - We ask that you accurately complete the *Patient Information Form*. You will be asked to update your information on a regular basis. A copy of your current insurance card will be kept in your chart. Please be sure to have the most current insurance card and information available for your appointments.

Insurance and Payment - Payment is expected at the time of service (copays, deductibles, & non-covered services). We accept cash, money order, check or credit card. (Visa, MasterCard, Discover)
Financial arrangements, if necessary, must be made **before** seeing the doctor.
Your financial responsibility and payment will depend on the complexity of the scheduled services and if the doctor is a participating provider with your insurance plan.
Insurance is billed as a courtesy to our patients and does not release the patient from payment responsibility. We allow 45 days for insurance to make payment and then payment responsibility is transferred to the patient.
Any surgical procedure that is to be schedule for self-paying patient must be paid in full one week prior to the surgery.
We charge a $100 cancellation fee for any surgical procedure that is cancelled with less than one weeks' notice.

Regardless of insurance coverage - The patient is ultimately responsible for payment.
Accounts are assigned to our collection services from the date of service if payment arrangements have not been made. I understand that delinquent accounts may be assigned to credit reporting collection service, Southern Oregon Credit Services, and there will be a $50.00 collection fee. Also, if it becomes necessary to assign collections on any amount owed on this or subsequent visits; the undersigned agrees to pay for all costs and expenses, including attorney fees. Non-covered services are the responsibility of the patient/guardian.

Returned Checks - A $25.00 service charge fee will be assessed for every check returned to us. The returned check plus the service charge fee *must* be paid in cash within five business days.

Appointment Cancellation – Reserve the right to charge a $25.00 fee for any appointment that is missed (no show) or <u>cancelled with less than 24 hours notice</u>. Your insurance company does not cover this fee. We reserve the right to discharge patient with 3 "no shows".

Patient Representatives - If you are unable to handle your own financial affairs, appoint someone to assist you. Advise the office with the name of the person you have assigned to assist with your finances, so that financial confidentiality is maintained.

I have read the above office and payment policy and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I hereby authorize the doctor to release information necessary to secure payment. This will ensure that responsible patients will not be penalized to cover costs incurred by others.

____ ________________________

Patient/Representative Signature Date

WILKS ADVANCED FOOT CARE
G. JASON WILKS, DPM, PC

Name ____ DOB ______________________________

Are you: ◯ new patient ◯ transfer of care from another podiatrist ◯ re-establishing care with Dr. Wilks

How did you hear about Dr. Wilks office: ◯ Primary Care ◯ Google ◯ Another Patient ◯ Facebook ◯ Yellow Pages ◯ other ________________________

Please state, in your own words, your reason(s) for coming into my office today:

____
____
____

Please list any surgical procedures you have had done:

____
____
____

Please check mark the problems that you currently have:

____ Weight Change
____ Fever
____ Fatigue
____ Chest Pain
____ Heart Palpations (rapidness, fluttering)
____ Syncope (fainting)
____ Dyspnea on Exertion (shortness of breath)
____ Orthopnea (lying-flat) (shortness of breath)
____ Peripheral Edema (foot swelling)
____ TB or Asthma
____ Hair Loss
____ Cough
____ Ulcers
____ Change in Appetite or bowel Habits
____ Nausea
____ Vomiting
____ Abnormal Pain
____ Arthritis
____ Joint Pain
____ Loss of Strength
____ Change in Pigmentation (skin color)
____ Change in Nails
____ Skin Texture
____ High Blood Pressure
____ Stroke
____ Vertigo
____ Numbness
____ Sensory Disturbance
____ Tremors
____ Paralysis
____ Goiter (swollen thyroid)
____ Polyphagia (excessive hunger)
____ Dryness of skin/hair
____ Anemia
____ Bleeding Disorders
____ Diabetes
____ Gout
____ Circulation Problems
____ Leg/Foot Cramps
____ Liver Disease
____ Kidney Disease
____ Thyroid Disease
____ Lung Disease
____ Heart Disease
____ Cancer
____ HIV/AIDS
____ Hepatitis A
____ Hepatitis B
____ Hepatitis C
____ Parkinson's
____ Wheezing

Signature of Patient/Guardian: ____________________________________ Date: ________________________

WILKS ADVANCED FOOT CARE
G. JASON WILKS, DPM, PC

MEDICATIONS & ALLERGIES

Patient Name: ____ Date of Birth: ______________________

If you have a current list of your medications, we can just make a copy.

Please list any **prescription medications**, **over the counter medications**, **vitamins**, **herbs** **or** **nutritional supplements** that you are now taking. Please include the **dosage amount** and the **times per day** you take them.

Please be as specific as possible

MEDICATIONS	DOSAGE	TIMES PER DAY

Allergies: Please include reaction you have to the allergy and the severity of it.
C= Critical **S**=Severe **MO**=Moderate **MI**=Mild

ALLERGY	REACTION	CIRCLE ONE
		C S MO MI
		C S MO MI
		C S MO MI
		C S MO MI
		C S MO MI
		C S MO MI
		C S MO MI
		C S MO MI
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