SOUTH HILL FOOT & ANKLE CLINIC
SOUTH HILL AMBULATORY SURGICAL CENTER
BORYS E. MARKEWYCH D.P.M.

3707 S. GRAND, SUITE A
SPOKANE, WA 99203
(509) 747-0274 FAX: (509) 747-3220

Patient Information:

First Name: ____________________ Last Name: ______________________________ M.I.:______

Suffix (Jr., Sr. III):______ SS#: __________________ Age: _____ Date of Birth: ______________

Marital Status: ☐ Married ☐ Single ☐ Domestic Partner ☐ Divorced ☐ Separated ☐ Widowed ☐ Minor

Gender: ☐ M ☐ F Address ____

City:________________ State: ______ Zip Code:__________

Contact Information: Home ( ) ___________ Cell ( )___________ Business ( )___________

Preferred Contact: ☐ Home ☐ Business ☐ Cell May we leave detailed messages at that number? ______

E-Mail: ____

Employed: ☐ Yes ☐ No Employer Name:________________ Occupation:________________

Emergency Contact: ______________________ Relation:___________ Phone #: ( )___________

Primary Care Physician: ________________________________ Physician Phone #: ( )___________

In order for us to file a claim on your behalf, this section must be completed in its entirety

Responsible Party for Account (if different than patient)

Name: ____________________________________ Relationship to Patient:________________

Address:______________________________ City: ___________ State: ____ Zip Code: ______

Contact Information: Home ( ) ___________ Cell ( )___________ Business ( )___________

Insurance Information:

Primary Insurance Name: ________________________ Plan Type: ☐ HMO ☐ PPO ☐ Other: _________

Policy #:______________________ Group #:__________________ Effective Date:______________

Insured Name:_____________________________ Employer:_______________________________

Date of Birth: ______________ SS#:______________ Relationship to Patient:__________________

Secondary Insurance Name:______________________ Plan Type: ☐ HMO ☐ PPO ☐ Other: _________

Policy #:______________________ Group #:__________________ Effective Date:______________

Insured Name:_____________________________ Employer:_______________________________

Date of Birth: ______________ SS#:______________ Relationship to Patient:__________________

How did you hear about South Hill Foot & Ankle Clinic?

☐ Google ☐ Website ☐ Facebook ☐ Patient or Friend Name: ______________________________

☐ Physician Reference – *please complete the following:*

Referring Physician Name: __________________________ *Physician Phone #: ( )*___________

☐ *Other (please specify):* ____

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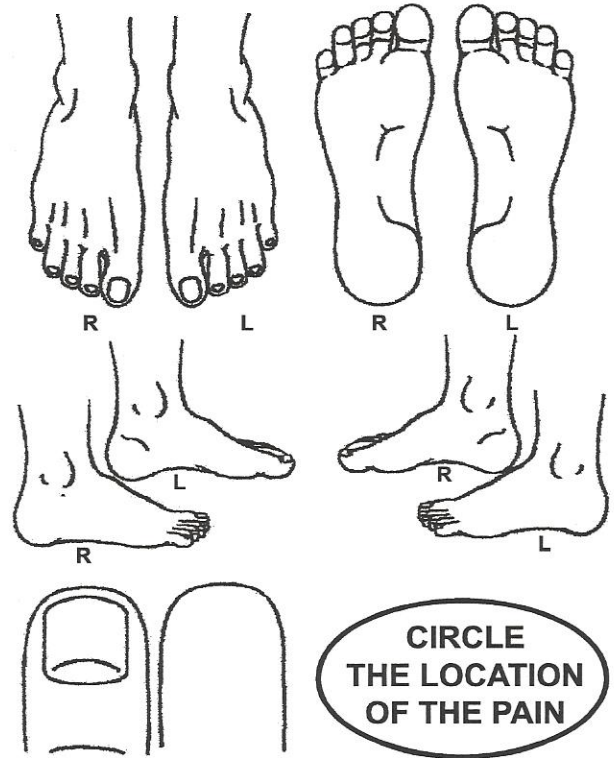
INITIAL PODIATRIC HISTORY



Description of Symptoms: ______________________________

____

____

Onset of pain/disability? ______________________________

____

Duration of pain/disability? ______________________________

____

What makes it hurt? ______________________________

____

____

What makes it better? ______________________________

____

____

Describe the symptoms of pain: ______________________________

____

Do you have any other problem with your feet or ankles? ______________________________

____

MEDICAL HISTORY

List all medical conditions you take medication for: ______________________________

____

List any serious injuries and the age at which they occurred: ______________________________

____

List any allergies and type of reaction: ______________________________

____

List all prior surgeries: ______________________________

____

List any medications you take on a daily basis – include pills, injectables, and vitamins: ______________________________

____

Do you use: ☐ Tobacco ☐ Alcohol ☐ Drugs Frequency of use: ______________________________

PLEASE PRINT

NAME: ______________________________

HEIGHT: __________ WEIGHT: __________ OCCUPATION: ______________________

SHOE SIZE: ______________

PATIENT MEDICAL HISTORY CONTINUED

Please circle all that apply to you:

Anemia	Cramps (feet, legs)	Migraines	Headaches	Arthritis
Diabetes	Numbness (feet, leg)	Asthma	Diarrhea	Phlebitis (clots)
Back Pain	Epilepsy	Fainting	Birth defects	Fibromyalgia
Gout	Stomach (pain, ulcer)	Emphysema	Heart Disease	Stroke
Cancer	High blood pressure	Tuberculosis	Chest Pain	irregular heart beat
Thyroid	Kidney disease	Corns/Callus	COPD	Radiation/Chemo
Fractures	Liver disease	HIV / AIDS	Prone to infection	Lupus
Osteoporosis	Parkinsons	Prolong healing time	Depression	
Glaucoma	Neuropathy	Edema (feet, legs)	Pacemaker	

Family Medical History:

Is there a family history of: Cancer_______ Diabetes_______ Heart Disease_______ Stroke_______

Assignment of benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) including Medicare, Medicaid, Private insurance and any other health/medical plan to issue payment check(s) directly to Borys E. Markewych D.P.M., South Hill Foot & Ankle Clinic/Ambulatory Surgical Center rendered to myself or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance including co-pays, co-insurance, and deductibles as defined by my insurance plan.

By signing this document I hereby give permission to Dr. Markewych to administer treatment, including photographing, and to perform such procedures as may be deemed necessary in the diagnosis and / or treatment of my foot / ankle condition. All such treatment and procedures shall be agreed upon by both parties. I, the patient (or guardian), have the right to refuse such treatments and / or procedures. Also by signing the clinic and surgical center are not responsible for any improper use or handling of appliances or samples given for treatment or procedures.

PLEASE PRINT

Office Policies and Procedures (Please read and initial)

Patient Treatment: It is our primary goal to restore and maintain the health of your feet. We strive to provide you with the highest quality podiatric care. If you have any questions regarding your treatment, please feel free to consult with Dr. Markewych. It is our responsibility to deliver the best health care possible. We highly value your confidence in our practice and we will make a sincere effort to satisfy all your podiatric needs. Your initials and signature will act as an authorization and consent for treatment.

____

Required Payments: You will be responsible to pay any co-payment, deductible, coinsurance or fees not covered by your insurance carrier at the time of services rendered. We do not accept letter of protection. We do not maintain balances for more than 60 days. You may choose to pay by cash, check, debit or credit card. We accept Visa and MasterCard. ________________

Monthly Statements: You will receive a statement only if you have an outstanding balance on your account. The statement will reflect any balance pending with your insurance carrier as well as any outstanding balance for services not covered by your insurance company. We request that if you receive a statement, that you make payment within 30 days of receipt. If your balance becomes delinquent past 60 days, your account will be referred to a collection agency. ________________

Patient Signature ____ **Date** ________________

Relationship (if applicable) ____