

Patient Information

Patient Name: _____ Date of Birth: _____
Social Security#: _____ Driver's License#: _____
Marital Status: (circle one) Single Married Divorced Widowed
Home Phone: _____ Cell Phone: _____
Street Address: _____ Mailing address: _____

Email address: _____

Employment Information

Occupation: _____
Employer: _____ Employer Address: _____
Employer Phone#: _____

Emergency Contact Information

Emergency Contact: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Address: _____

Referral Information

Were you referred by a physician? Yes No If yes, who: _____

OR

How did you hear about our office? _____

Physician Information

Full Name of Primary Care Provider: _____
Office Phone: _____
Full Name of DIABETIC Provider: _____
Office Phone: _____

Billing Information

Person Responsible for Account: _____

Relation to Patient: (circle one) Self Parent/Guardian

If patient is a minor, please provide parent/guardian information

Parent/Guardian Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Street Address: _____ Mailing Address: _____

Does patient have medical insurance: (circle one) Yes No

Insurance Information

Primary Insurance

Name of Insurance _____

Policy# _____ Group#: _____

Relationship to Subscriber: (circle one) Self Spouse Parent Other

Subscriber Name: _____ Subscriber SS# _____

Subscriber DOB: _____ Subscriber Phone#: _____

Secondary Insurance

Name of Insurance _____

Policy# _____ Group#: _____

Relationship to Subscriber: (circle one) Self Spouse Parent Other

Subscriber Name: _____ Subscriber SS# _____

Subscriber DOB: _____ Subscriber Phone#: _____

I hereby give permission to Dr Gent to examine/administer treatment as deemed medically necessary in the diagnosis and/or treatment of my foot/ankle problem(s). I request that payment of authorized benefits be made to Dr. Gent on my behalf. I also give permission to release necessary information to process my claims.

Signature of Patient or Patient Representative

Relationship

Date

Kitsap Foot & Ankle Clinic
David M. Gent, DPM
 900 Sheridan Road, Suite 101
 Bremerton, Wa 98310
 Phone (360) 377-2233 Fax (360) 377-9131

Patient Name: _____ **Date:** _____

Reason for Visit: _____

Height: _____ **Weight:** _____ **Shoes Size:** _____

Are you in good general health? Yes No If no, explain: _____

Are your feet tired at the end of the day? Yes No Do you have lower back pain? Yes No

Have you ever broken a foot or ankle? Yes No Any previous foot/ankle surgeries? Yes No

If yes, explain: _____ **If yes, explain:** _____

Do you use any tobacco products? Yes No If yes, what amount daily/how long? _____

Please check if you have (or have had) a problem with any of the following:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Alcohol Addiction | <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cramps/Numbness in Feet/Legs | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Diabetes: _____ | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Surgery (list below) |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Swelling of Feet/Ankles |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Toenail Problems |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bunion | <input type="checkbox"/> Gout | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Unequal Leg Lengths |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Hardening of the Arteries | <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Healing Problems | <input type="checkbox"/> Polio | <input type="checkbox"/> Weak Ankles |

Please list any surgeries, including dates and/or additional info we should be aware of? _____

Please check if you are allergic/sensitive to any of the following:

- | | | | | |
|--------------------------------------|--------------------------------|------------------------------------|-------------------------------------|-----------------|
| <input type="checkbox"/> Anesthetics | <input type="checkbox"/> Foods | <input type="checkbox"/> Materials | <input type="checkbox"/> Penicillin | Other: _____ |
| <input type="checkbox"/> Drugs | <input type="checkbox"/> Latex | <input type="checkbox"/> Novocaine | <input type="checkbox"/> Tape | Reaction: _____ |

Please list any prescription or over-the-counter medications you take on a regular basis: _____

Please check if there is any family history of any of the following:

- | | | | |
|-----------------------------------|--|---|-----------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatoid Arthritis | Comments/Other: _____ |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis | _____ |

Signature of Patient or Patient Representative _____ **Relationship** _____ **Date** _____

Acknowledgement of Privacy Practice

I acknowledge that I have either received a copy or was offered a copy of the Notice of Privacy Practices for the office of **Kitsap Foot & Ankle Clinic**. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services or in the performance of the **Kitsap Foot & Ankle Clinics** health care operations. The Notice of Privacy Practices also describes my rights and the responsibilities and duties of the **Kitsap Foot & Ankle Clinic** with respect to my protected health information. The Notice of Privacy Practices is also posted in the facility.

The Kitsap Foot & Ankle Clinic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosure in the Notice of Privacy Practices, I hereby specifically authorized disclosure of my protected health care information to the persons indicated below:

Any Member of My Immediate Family	Yes	No
Family Members Names: _____		

Spouse Only	Yes	No
Spouses Name: _____		
Other	Yes	No
Please Specify: _____		

I authorize Dr. Gent and/or his staff to call and leave a voicemail message concerning my health information (ie: labs, appointment instructions, prescription information, etc. at the following number: _____

Name of Patient

Date

Signature of Patient or Patient Representative

If not patient, relationship to patient

Signature of Witness

Date

Financial Policy

Thank you for choosing Kitsap Foot & Ankle Clinic for your podiatric needs. We are committed to your treatment being successful. The following is a statement of our financial policy, effective September 1st 2015.

Patients *without* Medical Insurance

- We will give you our best estimate. Dr. Gent and you will decide the best course of treatment for your situation. **Payment is due in full at time of service.**

Patients *with* Medical Insurance

- Co-pays are due at time of service.
- Deductible and co-insurance will be collected **same day** after your appointment if applicable.
- We cannot guarantee your insurance benefits. There may be additional amounts owing after insurance pays. Your insurance policy is a contract between you and your insurance company. We make a reasonable effort to ensure claims are paid within 60 days. However, if we are unable to get your claim paid within this time, we may bill the balance to you. It will be your responsibility to resolve the issue with your insurance company.
- Payment for services not covered by insurance is required at time of service.

Unfortunately, We are Unable to Offer Payment Plans

- Account balances are due in full within 30 days from receipt of statement. If you feel you are unable to agree to this, please let our office know in advance so that we may be able to assist you.
- Any remaining account balances must be paid in full prior to next appointment.
- A \$35.00 fee will be added for returned checks (NSF checks). All future payments will need to be either in cash or credit/debit card and your account will need to be brought current within 15 days.

Cancellations and No Shows

- Due to the high demand for appointments, a \$25.00 fee will be charged for missed appointments or appointments cancelled with less than 24 hours notice.
- If you have 3 or more no shows or last minute cancellations this will warrant automatic discharge from the practice.

If the patient is a minor, the parent who signs for treatment will be responsible for the account balance.

_____ have read, understand and agree to this financial policy for Kitsap Foot & Ankle Clinic. If you have any questions please feel free to ask to speak to our billing department.

Signature of Patient or Patient Representative

Relationship

Date