Kitsap Foot & Ankle Clinic

David M. Gent, DPM
900 Sheridan Road, Ste 101
Bremerton, WA 98310

Allan K. Doan, DPM
1950 Pottery Ave, Ste 120
Port Orchard, WA 98366

Phone (360) 377-2233 Fax (360) 377-9131

Patient Information

Patient Name: ______________________ Date of Birth: ______________

Social Security#: ______________

Male_____ Female____

Marital Status: (circle one) Single Married Divorced Widowed

Home Phone: ______________ Cell Phone: ______________

Street Address: ______________ Mailing address: ______________

______________ ______________

E-mail 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, Ste 101
Bremerton, WA 98310

Allan K. Doan, DPM
1950 Pottery Ave, Ste 120
Port Orchard, WA 98366

360-377-2233

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

If yes, explain:______________________________

Any previous foot/ankle surgeries? Yes No

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:

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

__ Anesthetics	__ Foods	__ Materials	__ Penicillin	Other:______________
__ Drugs	__ Latex	__ Novocaine	__ 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:

__ Diabetes	__ High Blood Pressure	__ Rheumatoid Arthritis	Comments/Other:______________
__ Gout	__ Kidney Disease	__ Tuberculosis	

______________________________ ______________ ______________

Signature of Patient or Patient Representative   Relationship   Date

Kitsap Foot & Ankle Clinic

David M. Gent, DPM
900 Sheridan Road, Ste 101
Bremerton, WA 98310

Allan K. Doan, DPM
1950 Pottery Ave, Ste 120
Port Orchard, WA 98366

Phone (360) 377-2233 Fax (360) 377-9131

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

Kitsap Foot & Ankle Clinic

David M. Gent, DPM
900 Sheridan Road, Ste 101
Bremerton, WA 98310

Allan K. Doan, DPM
1950 Pottery Ave, Ste 120
Port Orchard, WA 98366

Phone (360) 377-2233 Fax (360) 377-9131

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/Dr. Doan 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.

I_______________________________ 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**

KITSAP FOOT AND ANKLE CLINIC

900 Sheridan Street #101 Bremerton WA 98310
Phone: (360) 377-2233 Fax: (360) 377-9131

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize ____ to
release healthcare information of the patient named above to:

Name: ____

Address: ____

City: ______________________ State: __________ Zip Code: __________

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________________

____

☐ All healthcare information

☐ Other: ____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: ______________________ Date Signed: ______________________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.