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Sequim WA, 98382

REGISTRATION FORM

REFERRING PROVIDER:

Today's Date:	**PRIMARY CARE PROVIDER:**

PATIENT INFORMATION

Patient's Last Name:	**First:**	**Middle:**	◯ Single ◯ Married/ Partner ◯ Widowed

Preferred name:	**Primary Language:**	**Social Security #:**	**Birth date:**	**Age:**	**Sex:** ◯ M ◯ F ◯ Other

Emergency Contact Name and Relation: **Emergency Contact Phone Number:**	**Race:**	**Ethnicity:** ◯ Hispanic ◯ Non Hispanic	**Pharmacy:**

Mailing Address:

City:	**State:**	**Zip code:**	**Home phone:**	**Cell Phone:**

Employment Status ◯ Retired ◯ Student ◯ Disabled ◯ Fulltime ◯ Parttime	**Employer phone:**	**Employer**

Email Address:

Legal Guardian for minor patient:	**Relationship:**	**Home Phone:**	**Work:**

Advanced Care Directives: ***please provide a copy for your chart*** ◯ POLST ◯ DNR ◯ POA ◯ Living will ◯ Legal Guardian **Location of these documents:**	**Power of Attorney or Surrogate decision maker:** **First Name:** **Last Name:**

***** Are you currently in a SNF (Skilled Nursing Facility), AFH (Adult Family Home), Assisted Living, or Hospice? *****

☐Yes ☐No **Facility Name:** **Date of Admission:**

INSURANCE INFORMATION

Subscriber's Name:	**Subscriber's Social Security Number:**		**Subscriber Date of Birth:**
Primary Insurance co:	**ID number:**	**Group Name:**	**Group number:**
Secondary Insurance co:	**ID number:**	**Subscriber DOB:**	**Group number:**

People authorized to receive health care information	Relation
Name:	
Name:	
Signature:	Date:

PATIENT MEDICAL INFORMATION

Allergies: ☐No known drug

Medications *if you have more than can be listed, please provide your own list to be copied*

Medication:	Dose:	Frequency:

Vitamins/Herbs/Supplements

Name:	Dose:	Frequency

Blood thinner ☐Yes ☐No Type:

Cardiovascular

☐ Anemia ☐ Blood Clots/DVT/PE

☐ Calf/thing pain when walking

☐ Heart attack ☐ Heart trouble

☐ High blood pressure ☐ Pacemaker

☐ Poor circulation ☐ Stroke

☐ Swelling/Phlebitis ☐Vein problems

Respiratory

☐ Asthma

☐ Lung disease/Emphysema

☐ Sleep Apnea

Infections

☐ Hepatitis A ☐ Hepatitis B

☐ Hepatitis C ☐ HIV/AIDS

☐ STI's ☐ MRSA

Metabolic

☐ Bleeding problems

☐ Cancer

☐ Diabetes

A1c: **A1c Date:** **AM Glucose #:**

☐ Gout ☐ Liver problems ☐ Thyroid problems

☐ Weight gain ☐Weight loss

GI/GU	Psychiatric	Other
☐ Bladder infections ☐ Dialysis	☐ Depression	☐ Arthritis ☐ Glaucoma ☐ Hearing problems
☐ Kidney problems ☐ Prostate problems	☐ Anxiety	☐ Leg ulcerations ☐ Seizures ☐ Pregnancy
☐ Stomach ulcerations	☐ Psychiatric care	
☐ Alcohol use	☐ Drug dependance	☐ Tobacco use ☐ Current ☐ Previous
☐ Occasional ☐ Daily ☐ History of abuse	☐ Cannabis use	☐ Never used ☐ Chewing tobacco
☐ Caffeine use	☐ THC ☐ CBD	☐ Electronic cigarette
Cups per day: (Coffee/tea/soda/energy drink)		

Additional medical history:

Please list previous illnesses/injuries requiring hospital care and previous surgeries/procedures

Illness/ Surgery/ Injury/ Procedure	Year

Family History	Family History	Family History
Maternal	**Paternal**	**Sibling**
☐ Heart disease	☐ Heart disease	☐ Heart disease
☐ Diabetes	☐ Diabetes	☐ Diabetes
☐ Cancer	☐ Cancer	☐ Cancer
☐ Dementia	☐ Dementia	☐ Dementia

Additional family history:

Flu vaccine ☐Yes☐No **Date:** **Covid Vaccination** ☐Yes☐No **Dates:**

Pneumonia Vaccine ☐Yes☐ No **Date:**

Seatbelt usage ☐Yes☐No **Assistive devices:** ☐Cane ☐Walker ☐Wheelchair

Have you fallen in the last year? ☐Yes☐No **Number of falls:**

Do you feel unsteady on your feet? ☐Yes☐No

Have you broken any bones as an adult? ☐Yes☐No

Height (ft, in)	Weight (lbs.)	Shoe size:

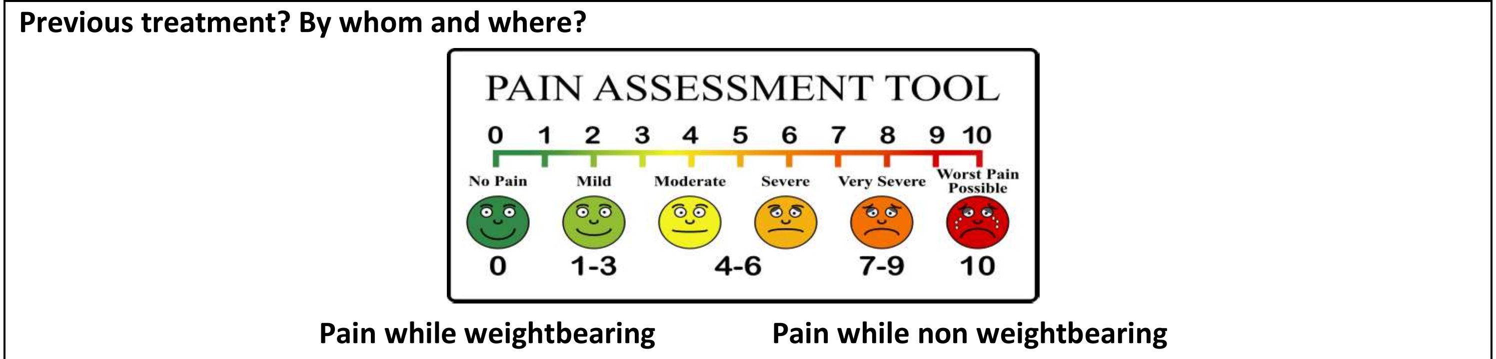
PLEASE DESCRIBE FOOT PROBLEM ☐ Left ☐ Right ☐ Both

Current foot or ankle problem and duration:

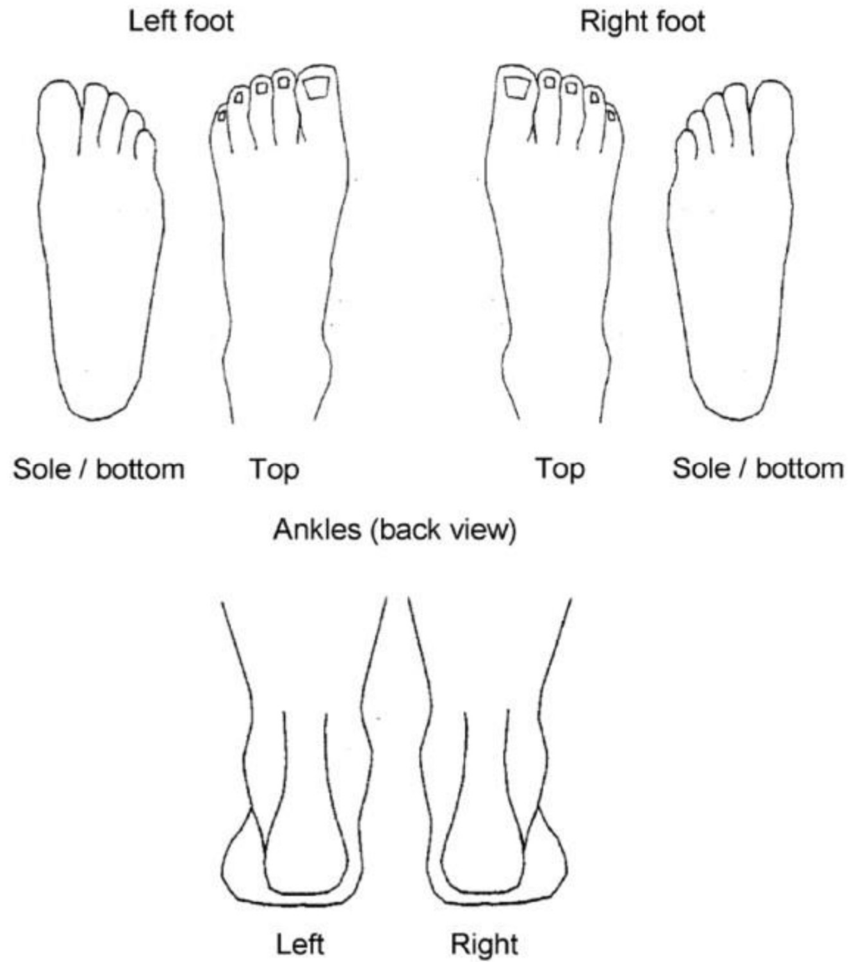
What makes it worse?

What makes it better?

Previous treatment? By whom and where?



Pain while weightbearing **Pain while non weightbearing**



Please mark pain locations

CONSENT FOR TREATMENT

Please read and initial each box and sign at the bottom.

☐ I hereby consent to treatment by Kitsap Podiatry.

☐ I have been presented with the opportunity to read/ retain the *Notice of Privacy Practices* by Kitsap Podiatry.

☐ *I understand that photographs, x-rays, and digital images may be recorded to document my care, and I consent to this. I understand that Kitsap Podiatry will retain ownership rights to these images, but I will be allowed to access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for time required by law. I understand that images that identify me will only be released and/or used outside the institution only upon written authorization from me or my legal representative.*

☐ I hereby authorize assignment of financial benefits from my insurance directly to Kitsap Podiatry for services rendered, as allowable under standard third-party contracts. I understand that I am ultimately and financially responsible for charges not covered by this assignment.

☐ I understand that I am responsible for any co-payments, deductibles, and co-insurance and/or any amounts not paid by my insurance.

☐ I am <u>not</u> receiving DSHS medical assistance, and I agree to pay for the services rendered. If I later become eligible for DSHS medical assistance, I agree to notify the billing office.

☐ I am <u>not</u> participating in an HMO/ Managed care plan and if I become retroactively covered, I acknowledge that an authorization for services may not be approved for services already received. I understand that if services are not covered, I am ultimately and financially responsible for billed charges.

☐ I authorize the payment of Medicare benefits be made to Kitsap podiatry for any services furnished by Kitsap Podiatry, Including physician services. I authorize any holder of medical or other information about me to release to Centers for Medicare and Medicaid services and its agents any information needed to determine these benefits or the benefits for related services.

☐ I authorize Kitsap Podiatry personnel to communicate with me by phone, mail, answering machine message, and/or email according to the information I have provided on my patient registration.

☐ I authorize Kitsap Podiatry, the physicians, and the staff to release medical and other information to the necessary insurance companies, third party payers, and/or other health care entities required to participate in my care.

I have read all of the preceding information provided to me and my signature serves as acknowledgement of a clear understanding of my financial responsibility. If my insurance company denies coverage and/or payment for services rendered to me at Kitsap Podiatry, I assume full financial responsibility.

Patient/ Guardian/legal Representative Signature	Date