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#: _____ Pharmacy: _____

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: _____

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Patient Name:_____ Date:_____

Reason for Visit:_____

_____

Height:_____ Weight:_____ Shoe size:_____

Are your feet tired at the end of the day? Yes No

Have you ever broken a foot or ankle? Yes No

If yes, explain:_____

_____

Do you have lower back pain? Yes No

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

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**

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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

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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**