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Bellingham
FOOT & ANKLE CLINIC

BELLINGHAM FOOT AND ANKLE CLINIC

520 BIRCHWOOD AVE STE A
BELLINGHAM, WASHINGTON 98225-1700
TELEPHONE (360) 734-3668
FAX (360) 676-8941

PATIENT INFORMATION

Completion of this information in its entirety is required at time of visit

Name:_____
First Last Middle Initial

S.S.N: _____-_____-_____ Birthdate: _____/_____/_____ Male ☐ Female ☐
Required for Insurance Coverage Month Day Year

Email:_____

Cell Number:(_____)_____ Home Phone:(_____)_____

Home Address_____
Street City State Zip code

Billing Address_____ Same as ☐ Home Address
Street City State Zip code

Pharmacy:_____
Pharmacy Name Location

In Case of EMERGENCY:

Spouse/Parent:_____ Phone:(_____)_____

Other Person (Not Spouse):_____ Phone:(_____)_____

How do you intend to pay?

*Insurance _____ Selfpay/Cash _____ Workers Compensation _____

*Name of Insured: _____ DOB of Insured: _____/_____/_____
Month Day Year

If someone other than the PATIENT is responsible for payment, please complete the following:

Responsible Party (ex. Company, Custodial Parent, etc.): _____

Phone:(_____)_____ Address: _____
Street City State Zip code

Reason for this visit: _____

When did symptoms start? _____ Severity of Symptoms? Mild Moderate Severe

Did symptoms start from an injury or illness? Y / N If so, have you been treated previously? Y / N

Other information:

Height _____ Weight _____ Shoe Size_____ *(More information required on back)*

Patient Medical Status: (Please check ALL that apply)

Anemia_____ Arthritis _____ Asthma _____ Cancer_____ Celiac Disease_____ Diabetes_____

Gout_____ Heart Disease_____ High Cholesterol_____ High Blood Pressure_____ Neuropathy _____

Peripheral Vascular Disease_____ Other_____

Allergies: (Please Check ALL that apply)

Adhesive Tape _____ Anesthesia_____ Aspirin _____ Codeine_____ Iodine_____ Latex_____

NSAID's_____ Penicillin_____ Sulfa_____ Other_____

Please List ALL Medications you are Currently Taking: *(You may provide a list with this form instead.)*

_____

_____

Who is your Primary Care Physician? Dr._____
First Last

Surgical History: *(Procedures and Dates)*

_____

_____

Social History:

Do you Currently Smoke? Y / N If yes, how much?_____

Did you Smoked in the Past? Y / N For How long?_____ When did you quit?_____

Do you Drink Alcohol? Y / N If yes, how many _____ drinks, per: Day_____ Week_____

If Diabetic, what was your last A1C Level? _____

I have completed this form in its entirety to the best of my ability. _____
Initials

I acknowledge all information given is accurate and truthful.
If any information is found fraudulent you may be held liable. _____
Initials

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collection of any amounts owed on this visit or future visits, I agree to pay for all costs, including attorney fees. I authorize the doctor to release this information necessary to secure payment of benefits.

Signature:_____ Date: _____

We require 24 hours notice for any cancellations. Please make checks payable to : "B.F.A.C". Thank You.