Patient Registration - Issaquah Foot and Ankle Specialists
(Please Print - You may complete this form on your computer, print, sign and fax to us at (425-392-6433)

Patient Information

Last Name | First Name | Middle Name | ☐ Male ☐ Female

Social Security # | Date of Birth | Age | ☐ Single ☐ Married ☐ Other

Street Address | City

State | Zip Code | E-mail Address

☐ Subscribe to E-Newsletter | Responsible Party | Relationship

Spouses Name | Primary Care Dr.

Emergency Contact Name | Emergency Contact Phone Number

Patient's Phone Numbers/Employment

Home | Work | Cell | Employer

Referred to Clinic by (Please let us know how you found us)

Referred by Doctor: | ☐ Friend/Family

☐ Internet Search ☐ Insurance Provider ☐ Yellow Pages Online/DEX ☐ Phone Book | Other:

Insurance Information (Please bring your insurance card with you to your appointment)

Insurance Provider (Primary) | Subscriber's First Name | Subscriber's Last Name

Employer | Co-Pay | Group Number

I.D. Number | Subscribers Social Security # | Birth Date

Patient's Relationship to Subscriber | ☐ Self ☐ Spouse ☐ Child | Other

Secondary Insurance Information - If Applicable (Please bring your insurance card with you to your appointment)

Insurance Provider | Subscriber's First Name | Subscriber's Last Name

Group Number | Policy Number | Subscribers Social Security #

Patient's Relation to Subscriber | ☐ Self ☐ Spouse ☐ Child | Other | Birth Date

Podiatric History

Primary Reason for Visit

Current Physical Activities

Shoe Size | Weight | Height

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Dr. Timothy Young and Dr. Brandon Nelson. I understand that I am financially responsible for any balance, whether billed to insurance or not. I also authorize Issaquah Foot & Ankle Specialists and my insurance company to release any protected health information required to gain authorization information and process my claims.

_____ Date

Patient/Guardian Signature

Patient Information
Health History

Allergies

☐ **No Known Drug Allergies**	☐ Adhesive/Tape	☐ Aspirin	☐ Codeine	☐ Demerol	☐ Sulfa	☐ Iodine	☐ Penicillin

☐ Anticoagulant Therapy	☐ Seafood	☐ Novocaine	Other

Current Medications (Please Include Prescriptions, Over-the-Counter and Vitamins)

Medications

Medical History (Please indicate past and present medical diagnosis)

Major Disease:

Diabetes	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Angina	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No
HIV/Aids	☐ Yes	☐ No
Stroke	☐ Yes	☐ No

Skin:

Rash	☐ Yes	☐ No
Skin Discoloration	☐ Yes	☐ No
Cancer, Tumors, Cysts	☐ Yes	☐ No
Ulceration	☐ Yes	☐ No
Psoriasis	☐ Yes	☐ No

Musculoskeletal:

Arthritis	☐ Yes	☐ No
Joint Diseases	☐ Yes	☐ No
Fractures	☐ Yes	☐ No
Gout	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No
Sciatica	☐ Yes	☐ No

Respiratory:

Asthma	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No
Lung Disease	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No

Foot Problems:

Ankle Pain	☐ Yes	☐ No
Bunion	☐ Yes	☐ No
Corns, Callouses	☐ Yes	☐ No
Flat Feet	☐ Yes	☐ No
Heel Pain	☐ Yes	☐ No
Ingrown Toenails	☐ Yes	☐ No
Plantar Warts	☐ Yes	☐ No
Plantar Fasciitis	☐ Yes	☐ No
Tired Feet	☐ Yes	☐ No

Cardiovascular:

Anemia	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No
Poor Circulation	☐ Yes	☐ No
Peripheral Vascular Disease	☐ Yes	☐ No
Swelling of Feet or Ankles	☐ Yes	☐ No
Phlebitis	☐ Yes	☐ No
Varicose Veins	☐ Yes	☐ No
Leg Pain when Walking	☐ Yes	☐ No
Anticoagulation Therapy	☐ Yes	☐ No

HEENT:

Difficulty Swallowing	☐ Yes	☐ No
Eye Problems	☐ Yes	☐ No
Hearing Problems	☐ Yes	☐ No
Ear Problems	☐ Yes	☐ No

Other Conditions Not Listed:

Surgeries

Name of Surgery and Date

Family Medical History

Check all conditions that apply to immediate family and indicate the relationship to patient

☐ High Blood Pressure	Relation		☐ Diabetes	Relation	
☐ Heart Disease	Relation		Other		Relation

Alcohol/Tobacco Use

Do you use tobacco products?	☐ Yes	☐ No	If Yes, How Much?		☐ Quit	Years Ago	
Do you drink alcohol?	☐ Yes	☐ No	If Yes, How Much?				

Consent

I certify that the above information is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

_____ Date

Patient/Guardian Signature

Financial Policy

We are committed to providing you with the highest medical and surgical care. In return, we ask you to be equally committed to being fully responsible for paying our fees. This will help in reducing our billing and administrative burdens, leaving more time for helping you. This dual commitment is the foundation of our relationship. Our goal is to minimize misunderstanding regarding fees and payments. We accept many different insurance plans, however all health plans are not the same and do not cover the same services.

0 Managed Care Patients/Private Insurance

If you are in a managed care plan (HMO, PPO, IPA) with which we participate, we abide by our contract with them. In either managed care plans or private plans, we will bill your insurance company; however you are responsible for paying the copays and deductible required by your plan at the time of treatment. In 30-45 days your insurance company will send you a statement that will tell you what you balance, if any, is to our office.

0 Medicare Patients

We accept assignment from Medicare; however, that does not meant that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any co-payments, which are usually 20% of the allowed amount for and item or service.

0 Uninsured Patients

Payment is due at the time of service.

0 All Patients

For your convenience, we will accept Visa, MasterCard, cash or check.
Any insurance balance over 90 days will become the entire responsibility of the patient.
Any patient balance over 30 days will be charged a $3.00 monthly billing fee.
There is a service fee of $40.00 for all returned checks.

Please note: It is the responsibility of the each patient to know his or her contract limitations. Specifically, if your policy requires a written referral prior to your visit, it is the patients responsibility to obtain that referral (or have it sent to our office) prior to making an appointment with our office. Denials from your insurance company based on lack of appropriate referral will be billed directly to the patient/responsible party.

I have read, understand and accept all responsibilities associate with this financial policy.

_____ Date

Patient/Guardian Signature

Durable Medical Equipment Policy

In the event that the patient leaves the office with an item recommended in the care and treatment of their foot condition (including, but not limited to custom made foot orthotics, ankle/foot orthotics, night splints, walking boots, pads, creams, solutions, etc.) it is understood that such items are non-returnable and non-refundable.

It is the policy of this office to help obtain insurance benefits regarding a patient's individual coverage of these items, by contacting the insurance company. This is a courtesy service that we are happy to provide; however the doctors or agents of the Issaquah Foot and Ankle Specialists are not held responsible for the accuracy of the information received. Information received by phone is not a guarantee of payment and if any doubt exists as to coverage of an item, it is highly recommended that you check your plan booklet for a detailed outline of your benefits or make a personal phone call to your insurance company. Please note, if these items are denied by insurance due to coverage limitations, the patient hereby accepts responsibility for the cost.

I have read, understand and accept all responsibilities associated with this Durable Medical Equipment Policy.

_____ Date

Patient/Guardian Signature

Authorization to Leave Personal Health Information by Alternate Means

Patient Name: _____ Date of Birth

(Please Print)

Please check all that apply:

- ☐ May leave detailed message on voice mail at home
- ☐ May leave detailed message on voice mail at work
- ☐ May leave detailed message on cell phone
- ☐ May leave detailed with spouse

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify health care provider should I change my preferences or any provided phone numbers.

_____ Date

Patient/Guardian Signature

The Federal Government requires us to collect the following information.

Language:

☐ English	☐ Spanish	☐ Russian	☐ Japanese
☐ Chinese	☐ Other		

Race:

☐ American Indian or Alaska Native	☐ Asian	☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander	☐ White	

Ethnicity:

☐ Hispanic or Latino	☐ Not Hispanic or Latino

Acknowledgement of Receipt
of
Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the notice.

Patient Name: _____
(Please Print)

_____ Date _____
Patient/Guardian Signature

Cancellation / No Show Policy

If you need to cancel or reschedule your appointment, kindly give us 24-hour notice. Patients who do not show for their appointment or cancel without providing 24-hour notice will be charged a $75.00 fee.

_____ _____
Patient/Guardian Signature