Seattle Office:
1545 NE 65th St
Seattle WA 98115
P: 206.528.0100

Edmonds Office:
21229 84th Ave West
Edmonds, WA 98036
P: 425.775.1505

www.activefootandankle.com

Patient Information (Please Print)

Name: Last_____First_____Middle Initial_____

Address: _____Unit_____ City _____State_____Zip_____

Home Phone: (___)_____Work Phone: (___)_____ Cell Phone: ( )_____

Email Address:_____

Birth Date:____/____/____SS#:_____ Age: _____Sex_____ Marital Status_____

Employed: Yes [ ] No [ ] Retired [ ] If yes, Full Time [ ] Part Time [ ] Student: Yes [ ] No [ ]

Employer: _____Occupation:_____

Reason for Today's Visit:_____

Primary Care Provider: Last_____ First _____Phone ( )_____

Clinic Name:_____ City:_____ Date of Last Visit:___/___/___

Today's Date: ___/___/___ How did you hear about us?_____

Person Financially Responsible For This Account

Name: Last _____First _____Relation to Patient: Self [ ] Spouse [ ] Other [ ]_____

Address: Street_____City_____State_____Zip_____

Home Phone: (___)_____Birth Date: ____/____/____ Social Security Number_____

Driver's License Number_____State_____Occupation_____

Employer Name_____ Phone: (___)_____

Third Party Insurance Information [ ] Not Applicable

Workers Compensation: Yes [ ] No [ ] State Insured: Yes [ ] No [ ] Date of Injury:____/____/____

Motor Vehicle Accident: Yes [ ] No [ ] Date of Injury:____/____/____

Claim Manager Name: _____ Phone: (___)_____

Primary Insurance/Subscriber Information (Please Print)

Insurance Company Name:_____ Phone: (___)_____

Does this insurance require a referral? Yes [ ] No [ ] If Yes, Authorization #_____

Subscriber's Name: Last _____First _____Middle Initial_____

Social Security #:_____Birth Date: ____/____/____ Relation to Patient: Self [ ] Spouse [ ] Child [ ]

ID/Policy Number: _____Group Number:_____

Effective Date of this Plan:____/____/____Subscriber Employer_____ Phone: (___)_____

Secondary Insurance/Subscriber Information (Please Print)

Insurance Company Name:_____ Phone: (___)_____

Subscriber's Name: Last _____First _____Middle Initial_____

Social Security #:_____Birth Date: ____/____/____ Relation to Patient: Self [ ] Spouse [ ] Child [ ]

ID/Policy Number: _____Group Number:_____

Effective Date of this Plan:____/____/____Subscriber Employer_____ Phone: (___)_____

Person to Contact in Case of Emergency (Not Living With You)

Name: _____Relationship to Patient: _____Phone: (____)_____

Private Insurance Authorization for Assignment of Benefits / Information Release

I hereby give permission to Active Foot & Ankle 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 Active Foot & Ankle on my behalf. I also give permission to release my information necessary to process my claims. I further agree that if the insurance payment is insufficient to cover the entire medical/surgical expense, I will be responsible for payment of the difference immediately.

Signature: _____Date_____

I authorize Active Foot & Ankle and/or staff to leave voicemail messages concerning my health information (i.e. lab results, prescriptions information, etc) at the following number:

Phone:_____ Patient Initials:_____

Active Foot & Ankle
Mark A. Kuzel, DPM

1545 NE 65th Ave, Seattle WA 98115
Phone: 206.528.0100 Fax: 425.775.1505

21229 84th Ave West, Edmonds, WA 98026
Phone: 425.775.1505 Fax: 425.775.1505

Patient Name: _____Date: _____

Please List all medications taken on a regular basis:

_____

_____

Please list anything to which you have an allergy, or to which you are sensitive (i.e. drugs, adhesive tapes, Betadine, etc.):

_____

_____

Check and of the following that you have (or have had) a problem with:

( ) Foot/leg injuries
( ) Foot/leg surgeries
( ) Foot/leg cramps
( ) Foot/leg numbness
( ) Knee Pain
( ) Unequal leg length
( ) Weak Ankles
( ) Bunions
( ) Tonail problems
( ) Skin Problems
( ) Low Back Pain
( ) Alcohol Addiction
( ) Anemia
( ) Arthritis
( ) Asthma
( ) Unusual bleeding
( ) Bladder
( ) Blood disease
( ) Bronchitis
( ) Bursitis
( ) Cancer
( ) Circulations Problems
( ) Diabetes
( ) Drug Addiction
( ) Emphysema
( ) Epilepsy
( ) Fainting Spells
( ) Gout
( ) Hardening of arteries
( ) Healing problems
( ) Heart Problems
( ) Hepatitis
( ) High blood pressure
( ) HIV
( ) Kidney Disease
( ) Lung Problems
( ) Neurological disorder
( ) Major Operation
( ) Polio
( ) Rheumatic Fever
( ) Stomach ulcers
( ) Thyroid Problem
( ) Tuberculosis
( ) Varicose Veins
( ) Other _____

Staff:_____

_____

Do you smoke? ( ) NO ( ) YES Number of packs per day_____ Number of Years_____

Height:_____ Weight: _____ Shoe Size: _____

Family History:

Is there a family (blood relative) member with a history of:

( ) Diabetes
( ) High blood pressure
( ) Rheumatoid arthritis
( ) Gout
( ) Kidney Disease
( ) Tuberculosis

Signature: _____ Date: _____

Family and Friends Authorization

I understand that my healthcare information at Active Foot & Ankle is protected and I have received a copy of their Notice of Privacy Practices.

The name(s) listed below are family members or friends to whom I wish to grant access to my health care information. I will rely on the professional judgment of my provider and his/her designee to share such information, as they deem necessary.

I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Informed form.

I understand that some information is considered "sensitive." I understand that I must check the specific boxes in order for my provider or his/her designee to release any "sensitive" information.

- ☐ Mental Health/Psychiatric Disorders (including depression)
- ☐ Chemical Dependency (drug and alcohol abuse/treatment)
- ☐ HIV / AIDS Virus
- ☐ Sexually Transmitted Diseases

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time.

NAMES	RELATIONSHIP
1. _____	_____
2. _____	_____
3. _____	_____

EMERGENCY CONTACT INFORMATION

Name:_____ Relationship:_____

Phone Number: _____Home_____ Work_____Mobile_____

Phone Number: _____Home_____Work_____Mobile_____

Patient Name (Print):_____DOB:_____

Patient Signature: _____Date:_____

Witness Signature:_____Date:_____