PODIATRY ASSOCIATES NW
515 Minor Avenue, Suite 240
Seattle, WA 98104

podiatryassociatesnw.com
206.420.3119 (O)
206.453.5912 (F)

Patient Registration Form

Select Location:

- ☐ Bellevue Commons
  1200 112th Ave NE, STE B250
  Bellevue, WA 98004
- ☐ Swedish Issaquah
  751 NE Blakely Dr, 3rd FL
  Issaquah, WA 98029
- ☐ Swedish Redmond
  18100 NE Union Hill Rd
  Redmond, WA 98052
- ☐ Swedish West Seattle
  3400 California Ave SW, STE 210
  Seattle, WA 98116

Appointment Date ____________________

Name ____________________
First MI Last

Address ____________________

City __________ **State** _____ **Zip** ________

Email ____________________

Preferred Language

☐ English ☐ Other ____________________

SSN ____________________

Date of Birth ____________________

Phone ____________________ Cell/Work/Home

Alt. Phone ____________________ Cell/Work/Home

Contact preference ☐ Phone ☐ Alt. Phone ☐ Email

Gender ____________________

Race ☐ American Indian ☐ Asian ☐ African American

☐ Caucasian ☐ Pacific Islander ☐ Other __________

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Other

MRN: ____________________
(For office use)

Employer ____________________

Occupation ____________________

Emergency Contact Information:

Name ____________________

Relationship ____________________

Phone ____________________

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

Responsible Party ____________________

Address ____________________

Primary Care Physician ____________________

Who referred you to our office? ____________________

____

Workers Compensation Claim: YES / NO

Reason for Visit ____________________

____

Primary Insurance ____________________

Address ____________________

Insurance ID ____________________

Group ID ____________________

Subscriber ____________________

Relationship ____________________

Secondary Insurance ____________________

Address ____________________

Insurance ID ____________________

Group ID ____________________

Subscriber ____________________

Relationship ____________________

I give my consent for services to be rendered by Podiatry Associates NW. I acknowledge that I am financially responsible for all charges and authorize my insurance benefits to be paid directly to my physician. I authorize Podiatry Associates NW and any healthcare organization or insurance company to release information necessary to process this claim.

Note: If the patient is under 18 years of age, the accompanying parent is financially responsible.

Signature ______________________________ **Date** ____________

Name and Relationship (if other than patient) ______________________________

PODIATRY ASSOCIATES NW

Patient Health History

Medical History/Systems Review (Please check if applicable):

☐ Fever/chills	☐ Anemia	☐ Shortness of breath	☐ Joint pains
☐ Recent weight loss	☐ Excessive bleeding/bruising	☐ Leg cramps	☐ Instability
☐ Extreme fatigue/weakness	☐ History of blood clots	☐ Gastric reflux	☐ Gout
☐ Frequent headaches	☐ Varicose veins	☐ Nausea/vomiting	☐ Leg/foot swelling
☐ Seizures	☐ Congestion/Hay Fever	☐ Diarrhea	☐ Non-healing wounds
☐ Stroke	☐ Difficulty with vision	☐ Constipation	☐ Osteoporosis/Osteopenia
☐ Rashes/Eczema	☐ Chest pain	☐ Kidney problems	☐ Diabetes
☐ Athlete's Foot	☐ Heart attack	☐ Frequent urination	☐ Sleep apnea
☐ Problems with circulation	☐ Heart disease	☐ History of kidney stones	☐ HIV positive/AIDS
☐ Nosebleeds	☐ High blood pressure	☐ Liver problems/Hepatitis	☐ Artificial joints

☐ Other ____

Past Surgical History/Hospital Stays

Date of Surgery/Stay	Details

Family Medical History (Please indicate affected relatives)

Peripheral artery disease		Reaction to anesthesia	
Stroke		History of blood clots	
Heart disease		Cholesterol	
High blood pressure		Kidney Trouble	
Rheumatoid arthritis		Drug addiction	
Diabetes		Cancer	

List medications: ____

____

____

Allergies: ____

____

Do you currently use or consume the following?

Caffeine	Cups per day:	Alcohol	Amount per week:
Tobacco	Packs per day:	Recreational Drugs	

Patient Name ______________________________ **Date of Birth** ____________________

Signature ______________________________ **Date** ____________________

Name and Relationship (if other than patient) ______________________________

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PORTABLILITY AND ACCOUNTABILITY ACT

Patient Name ____ **Date of Birth** __________________

By my signature below, I acknowledge that I received a copy of the **Notice of Privacy Practices for Podiatry Associates NW**.

This authorization grants permission to the Designated Party(ies) named below to exchange my private medical information with Podiatry Associates NW, and any authorized representative thereof, without restriction in terms of content, purpose, or means of transmission. This authorization includes, but is not limited to: making or confirming appointments; accessing any and all imaging, laboratory, or test information; access to telephone communication and answering machine messages as well as other common means of communication; be made aware of my diagnosis, prognosis, and treatment plans; direct discussion of my health with my doctor or other provider; and have access to my financial information as it relates to my health.

Name of Designated Party	Relationship	Phone Number

Signature ____ **Date** _________________________

Name and Relationship (if other than patient) ____