West Campus Foot & Ankle Clinic

33801 1st Way South, Suite 105, Federal Way, WA 98003 · Tel 253-838-8377 · Fax 253-838-9474

PATIENT REGISTRATION

Patient Name: _____ DOB: _____ SSN _____

Address: _____

City: _____ State: _____ Zip: _____ Phone _____

Employer: _____ Work Phone: _____ Cell# _____

Spouse Name: _____ DOB: _____ SSN _____

Spouse Employer: _____ Work Phone: _____

Is this a work related injury? Yes _____ No _____ If yes, date of injury: ____/____/____ Gender *(circle)* M or F

Attending Physician: _____ Phone # _____

How did you hear about us? _____

Primary Insurance	Secondary Insurance
Insurance:	Insurance:
Subscriber ID:	Subscriber ID:
Group Number:	Group Number:
Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB:
Subscriber Employer:	Subscriber Employer:

The above information is true to the best of my knowledge. I understand I am responsible for charges associated with medical services and agree to pay all bills within 30 days from the receipt of statement, unless other agreements/arrangements are made. I authorize the physician and clinic to release any information to process insurance claims. I also authorize my insurance to directly pay the clinic.

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

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MEDICAL INFORMATION

Patient Name: _____ Date: _____

What is the foot or ankle problem that brings you to the office today? Please be specific:

_____

Current Medical Conditions:
(please list all conditions even if no medication is needed)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Medications

1. _____ dose _____
2. _____ dose _____
3. _____ dose _____
4. _____ dose _____
5. _____ dose _____
6. _____ dose _____
7. _____ dose _____

Family Physician: _____ City _____ Last Visit _____

Have you or do you currently use any foot/shoe inserts in your shoes? _____

Have you ever had any of the following? Please check and write the start date you were affected.

_____ Arthritis	_____ Thyroid condition	_____ Liver trouble	_____ Anemia	_____ Aids
_____ Asthma	_____ Stomach problems	_____ Kidney trouble	_____ Blood disease	_____ HIV
_____ Shortness of breath	_____ Diabetes	_____ Heart trouble	_____ Hepatitis	_____ TB
_____ Cancer	_____ Gout	_____ High blood pressure	_____ Bleeding problems	
_____ Stroke	_____ Slow healing	_____ Rheumatic fever	_____ Blood clots / embolism	
_____ Heart attack				

Childhood Illnesses: _____ measles _____ mumps _____ Chicken pox _____ Rheumatic fever _____ Scarlet fever

Previous injuries (fractures, dislocations, car accidents, etc.) _____

_____

Family History of Medical Illnesses	Mother	Father	Grandparents	Siblings
Cancer				
Stroke				
High blood pressure				
Heart Problems				
Diabetes				

Previous surgeries (including same day surgery):

Reason: _____ Date: _____
Reason: _____ Date: _____
Reason: _____ Date: _____
Reason: _____ Date: _____
Reason: _____ Date: _____
Reason: _____ Date: _____

Allergies to medications: [ ] I have no known allergies to medications or [ ] adhesive tape [ ] codine [ ] sulfa [ ] penicillin
[ ] local anesthetic [ ] iodine [ ] other: _____

Coffee Usage: [ ] Yes [ ] No Cups per day:
Alcohol Use: [ ] Never [ ] Occasional, # drinks per week _____

Tobacco Use: [ ] None [ ] Pipe
[ ] Cigarettes Number of years:

[ ] Quit on: _____
[ ] Cigar [ ] Chewing Tobacco
Packs per day:

Height: _____ Weight: _____ Shoe Size: _____ Shoe Width: _____

I testify that the above information is accurate to the best of my knowledge.

Signature: _____ Relationship (if minor) _____ Date: _____