BELLINGHAM FOOT CARE CENTER
DAVID L. CUTLER, D.P.M.

PATIENT INFORMATION:

Name: ____
Last   First   Middle Initial

Mailing Address: ______________________________________ ________
Street   Apt/Unit #

______________________________ ____ __________
City   State   Zip Code

Phone: Home (   ) ______-__________   Cell (   ) ______-__________
Work (   ) ______-__________

Sex: ☐ **Male** ☐ **Female**

Date of Birth ___/___/____ **Social Security Number:** ______________

Referring Physician: ______________________________________

Employer Name/Address: ______________________________________
Occupation: ______________________________________

Emergency Contact: ______________________ **Phone:(   ) ____-______**
Relation to patient: ______________________

RESPONSIBLE PARTY (IF PATIENT IS A MINOR):

Name: ____
Address: ____
Street   City   State   Zip

Phone: Home(   )____-______ Work(   )____-______ Cell(   )____-______

Relation to Patient   Mother   Father   Other ______________

INSURANCE INFORMATION:

Primary Insurance Name: ________________ **Insured Name:** ____________

☐ **See Copy of Card - If card is not available please fill out the following:**
Policy Id# ______________________ **Policy Group #** ____________

Secondary Insurance Name: ________________ **Insured Name:** ____________

☐ **See Copy of Card - If card is not available please fill out the following:**
Policy Id# ______________________ **Policy Group #** ____________

Insurance Authorization and Fee Agreement:

I request that payment of authorized benefits be made on my behalf to Dr. David Cutler for any services furnished me by him. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine the benefits payable for related services. Co-payment is due at the time service is rendered. I further understand that I am ultimately responsible for payment of any charges due to Dr. Cutler for services performed.

______________________________   ______________
Patient or Guardian Signature   Date

☐ **I acknowledge that I have received a copy of the HIPAA "Notice of Information Practices"**

Name:______________________________

Height:_____'_____"   **Weight:**________   **Shoe size:**________

What specific problem brings you to our office (such as ingrown nails, bunions, corns, etc.)______________________________

How long have you had this problem?______________________________

Have you had previous foot care? □ Yes □ No

Who is your primary care physician?______________________________

Are you seeing a doctor now for any health problems? □ Yes □ No

If yes, please explain:______________________________

____

What medications are you currently taking?______________________________

____

____

My general health is: □ Good □ Fair □ Poor

I am allergic to:

□Aspirin □Codeine □Demerol □Iodine/Seafood

□Novocaine □Penicillin □Sulfa □NO ALLERGIES

Other:______________________________

Nature of reaction:______________________________

Do you smoke? □Yes □No

If so, amount per day__________**since age**__________

Do you drink alcohol? □Yes □No

If so, number of drinks per day, week or month:______________________________

Health problems, past and present:

□NONE

□Cancer-Where?__________________

□Asthma

□Heart attack

□Tumors

□Seizure disorders

□Circulation problems

□Swelling of feet or legs

□Stomach ulcers

□Stroke

□Arthritis

□Diabetes

□Heart problems

□Tuberculosis

□Gout

□High blood pressure

□Kidney/Bladder problems

□Nervousness

□Other________________