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** ____/____/_____

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**_____