NATHAN L LARSON, D.P.M.

Bellingham
FOOT & ANKLE CLINIC

BELLINGHAM FOOT AND ANKLE CLINIC

520 BIRCHWOOD AVE STE A
BELLINGHAM, WASHINGTON 98225-1700
TELEPHONE (360) 734-3668
FAX (360) 676-8941

PATIENT INFORMATION

Completion of this information in its entirety is required at time of visit

Name:_____ Birthdate:_____
Last First Middle

S.S.N: _____-_____-_____ Primary Care Physician:_____

Male ____ Female ____ Email:_____

Cell Number:(_____)_____ Home Phone:(_____)_____

Home Address_____
Street City State Zip code

Billing Address_____ Same as Home Address ☐
Street City State Zip code

Employer:_____ Phone:(_____)_____ Occupation:_____

Spouse/Parent:_____ Phone:(_____)_____

Spouse Employer:_____ Phone:(_____)_____

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

Responsible Party/ Custodial Parent:_____ Phone:(_____)_____

Relationship to Patient:_____ S.S.N:_____-_____-_____

Address:_____ Employer:_____

In Case of EMERGENCY:

Relative to Patient (Not Spouse):_____ Phone:(_____)_____

Other Person to Contact (Not Relative) :_____ Phone:(_____)_____

Reason for this visit: Illness_____ Injury_____ Job Related Injury_____ Auto Accident_____ Other____

Date of Injury or Onset of Problem:_____/_____/_____ Explain Symptoms:_____

_____

Workers Compensation Carrier:_____ Phone:(_____)_____

Other information:

Height_____ Weight_____ Shoe Size_____ Flat Feet: Y____/ N____ High Arches: Y____/ N____

How do you intend to Pay? Cash____ Check____ Insurance____ Medicare____ Welfare____ Other____

Primary Insurance:_____ Phone:(_____)_____

Name of Insured:_____ Policy #:_____ Insured Birthdate:____/____/____

Secondary Insurance:_____ Phone:(_____)_____

Name of Insured:_____ Policy #:_____ Insured Birthdate:____/____/____

Patient Medical Status: (Please check ALL that apply)

Diabetes_____ High Blood Pressure_____ Heart Disease_____ Arthritis_____ Neuropathy _____

Asthma_____ Anemia_____ Gout_____ High Cholesterol_____ Other_____

Allergies: (Please Check ALL that apply)

Penicillin_____ Sulfa_____ Codeine_____ Adhesive Tape_____ Local Anesthetic_____

Latex_____ Iodine_____ NSAID's_____ Aspirin_____ Other_____

Please List ALL Medication you are Currently Taking:

_____

_____

_____

Are you currently taking any Blood Thinners? Y_____ / N_____

Social History:

Do you Currently Smoke? Y_____/ N_____ If yes, how much?_____

Have you Smoked in the Past? Y____ / N____ How long?_____ When did you quit?_____

Do you Drink Alcohol? Y_____/ N_____ If yes, how much?_____

How did you hear about us? Online_____ By a Friend_____ Referred by Doctor_____

Name of Physician who referred you:_____

What pharmacy do you use for Medications? _____

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collection of any amounts owed on this visit or future visits, I agree to pay for all costs, including attorney fees. I authorize the doctor to release this information necessary to secure payment of benefits.

Signature:_____ Date:_____

We require 24 hours notice for any cancellations. Please make checks payable to : "B.F.A.C". Thank You.