Mill Creek Foot & Ankle Clinic

Joseph N. Hall, D.P.M / Joyce Yan D.P.M.
16708 Bothell-Everett Hwy, Suite 204, Mill Creek, WA 98012
Phone: 425-482-6663 Fax: 425-482-6665

Patient Information

Date: _____

Name: _____ SS#: _____
Last First middle initial

Address: _____ City/State/Zip: _____

Email: _____

Home #: _____ Cell #: _____ Work #: _____

Gender: M F Age: _____ Birthdate: _____ Single Married Widowed

Race: American Indian Asian Black Hispanic Pacific Islander Caucasian Other

In case of emergency notify: _____ Relationship: _____ Phone: _____

Patient Employer: _____ Occupation: _____

Primary Care Physician/Clinic: _____

City: _____ State: _____ Phone: _____

Whom may we thank for referring you to our office: Internet Phonebook Insurance Website Mail/Coupon

Friend Referral (Name): _____

Physician Referral (Name/Address/Phone): _____

Insurance Information:

Primary Insurance: _____ ID #: _____ Group #: _____

Subscriber Name _____ Birthdate: _____

Relation to Patient: _____ Employer: _____

Secondary Insurance: _____ ID #: _____ Group #: _____

Subscriber Name: _____ Birthdate: _____

If work/auto related injuries, DOI/ L&I #: _____

Assignment and Release: The above named doctor may use my health care information and may disclose such information to the patients Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____
Signature of Patient, Parent/Guardian or Personal Representative Date

Print name of Patient, Parent or Guardian _____

Mill Creek Foot & Ankle Clinic

Joseph N. Hall, D.P.M / Joyce Yan D.P.M.
16708 Bothell-Everett Hwy, Suite 204, Mill Creek, WA 98012
Phone: 425-482-6663 Fax: 425-482-6665

What is the nature of your foot complaint:

_____

_____

Do you smoke: _____ How much: _____ Drink Alcohol: _____How much (circle one): rarely/occasionally/daily

Height: _____ Weight: _____ Shoe Size: _____ Width (circle one): Narrow/Regular/Wide

Are you subject to profuse bleeding? No Yes

Have you had any serious illness or operation? No Yes

If yes, please describe: _____

Do you have low back pain? No Yes

Please check if you have had any of the following:

- □ Anemia
- □ Asthma
- □ Arthritis
- □ Cramps in feet/legs
- □ Diabetes, Insulin
- □ Diabetes, Orally Controlled
- □ Gout
- □ Heart Problems
- □ Hepatitis
- □ High Blood Pressure
- □ High Cholesterol
- □ Immune Deficiency
- □ Kidney Problems
- □ Liver Problems
- □ Numbness in feet/legs
- □ Swelling in ankles/feet
- □ Thyroid Problems
- □ Tuberculosis
- □ Varicose Veins
- □ Other _____

Allergies:

- □ No Known Drug Allergies
- □ Adhesive Tape
- □ Contrast Dye
- □ Iodine
- □ Latex
- □ Penicillin
- □ Other Medication:

_____

Please Note All Current Medications:

Name	Dosage	Frequency

Acknowledgement of receipt of Notice of Privacy Practices: I acknowledge that I was provided the Notice of Privacy Practices and that I have read and understand it.

_____ _____

Signature of Patient, Parent/Guardian or Personal Representative Date