Dr. Kirk D. Sherris, DPM
Certified, American Board of Podiatric Surgery
Certified, American Board of Podiatric Medicine

20730 Bond Rd. NE
Suite 120
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Phone: 360-434-0539
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www.libertybaypodiatry.com

Liberty Bay Foot & Ankle

Patient Information

Patient Name_____ Social Security #_____ Birth date _____
Street Address_____ City/State_____ Zip _____

Home Ph #_____Cell Ph #_____ Email _____ Gender: M F Marital Status: S M W SEP

Spouse or Parent's Name _____

_____

Emergency Contact: Name _____

Phone #:_____

PERSON RESPONSIBLE FOR BILLS	
Name	Date of Birth
Address	Employer
Social Security Number	Medicare Number
Primary Insurance Name	Subscriber's Name
Policy Number	Group number
Secondary Insurance Name	Subscribers name
Policy Number	Group number

HOW DID YOU HEAR ABOUT THE PRACTICE? (circle one): **Internet/Google** **Friend/Family**

Doctor Referral (who?) _____ **Insurance** **Website** **Facebook**

NAME OF YOUR PRIMARY HEALTH CARE PROVIDER _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS: PLEASE READ

Under all circumstances, I agree to final responsibility for my account. I authorize Liberty Bay Foot and Ankle and/or Kirk D. Sherris, D.P.M. to release medical records to designated insurance companies to facilitate payment of authorized benefits.

I hereby give my permission to the doctors of Liberty Bay Foot and Ankle to examine, to photograph, to administer treatment and to perform minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle problem.

Signature _____ Date _____

Parent Signature (if minor) _____ Date _____

MEDICARE PATIENTS:

Medicare authorization: I authorize the Dr. to release to the Federal Government or its designated agent, information on this or related medical claims. I permit a copy of this authorization to be used in place of the original and request payment of insurance benefits to be made to myself or to the doctor if assignment is accepted.

Some services are not considered "medically necessary" as determined by Medicare and Welfare. This includes but is not limited to, routine foot care, trimming of nails, corns or calluses, use of orthotics or other shoe inserts. When in doubt, we recommend that you contact Medicare to find out if certain services are covered.

Signature _____ Date _____

Please turn form over and complete

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PLEASE DESCRIBE YOUR FOOT PROBLEM AND STATE ONSET OF INJURY

_____
_____
_____

MEDICAL HISTORY

PLEASE LIST INCIDIENTS AND APPROXIMATE DATES FOR THE FOLLOWING:

ACCIDENTS: _____

SURGERIES: _____

OTHER HOSPITALIZATIONS: _____

MEDICATIONS YOU TAKE (INCLUDE ASPIRIN, ANTACIDS, BIRTH CONTROL PILLS, VITAMINS, ETC) _____

_____
_____
_____

Allergies or Reactions to Medications: **(check if yes)** __Penicillin __Sulfa __Other Antibiotics __Codeine __Novocaine or Local Anesthetic __Iodine __Adhesive Tape __Soaps __Aspirin __Latex __Other? What?	**Medical Conditions:** **(check if yes)** __Rheumatic Fever __Scarlet Fever __Epilepsy or Convulsions __Heart Disease __Heart Attack __High Blood Pressure __Syphilis or Gonorrhea __Tuberculosis __Hepatitis (A, B or C) __Diabetes __Insulin __Med __ Diet __Skin Problems, type _____ __Kidney Problems __Arthritis __Cancer, type _____ __HIV __Liver Disorder __Stroke __Lung or Respiratory Problems __Stomach or Intestinal Ulcers __Bleeding Disorders __Circulation Problems __Gout __Other Medical Conditions _____ _____	**Are there any members of your family (parents, grandparents, children, siblings) who have the following?** **(check if yes)** __Diabetes __Heart Disease __Foot Problems __Stroke __Cancer **Social History** **(check if yes or no)** Do You Drink Alcohol? ___Yes __No If yes, how much? _____ Do you drink coffee, tea or cola with caffeine? ___Yes __No If yes, how much daily? _____ Do you use tobacco? __Yes __No If yes, how much daily? _____