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

20730 Bond Rd. NE
Suite 201
Poulsbo, WA 98370

Phone: 360-434-0539
Fax: 877-768-9754

www.libertybaypodiatry.com

Liberty Bay Foot & Ankle

Patient Information

Patient Name_________________________________ Social Security #____________________ Birth date _________
Street Address_________________________________ City/State______________________________ Zip __________

Home Phone #_____________ Cell Phone #______________ Gender: M F Marital Status: S M W SEP

Email _________________________-__

Spouse or Parent's Name____________

Contact In Emergency: 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

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE? ________________________________
Family Dr.__________________________________ **Last Visit** ________________________________

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 (NEXT PAGE)

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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)	Medical Conditions: (check if yes)	Are there any members of your family (parents, grandparents, children, siblings) who have the following? (check if yes)
__Penicillin __Sulfa __Other Antibiotics __Codeine __Novocaine or Local Anesthetic __Iodine __Adhesive Tape __Soaps __Aspirin __Other? What?	__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 _____________________________ _____________________________ _____________________________	__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?_____________