ALDERWOOD
3500 188th Street SW, Suite 110
Lynnwood, WA 98037
(425) 778-5666 | Fax (425) 771-5374
aafcclinic.com

ALDERWOOD ANKLE & FOOT CLINIC

LAKE STEVENS
9514 4th St. NE, Suite 201
Lake Stevens, WA 98258
(425) 397-7401 | Fax (425) 397-7627
lkfcclinic.com

Patient Information

DATE _____ **ACCT #** _____

NAME _____
First Middle Last

ADDRESS _____
Street City State Zip

TELEPHONE (Home) _____ (Mobile) _____

(E-Mail) _____

PREFERRED CONTACT # HOME ☐ MOBILE ☐ BIRTHDATE _____ AGE _____

SSN _____ - ____ - _____ MARITAL STATUS _____ SEX: Male ☐ Female ☐

HEIGHT _____ WEIGHT _____ SHOE SIZE _____ PREFERRED LANGUAGE _____

ETHNICITY/RACE (Please check all that apply) Native American/Alaskan Native ☐ Hispanic/Latino ☐ Asian ☐
Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Prefer Not to Specify ☐

PREFERRED PHARMACY _____ PRIMARY CARE PROVIDER _____

PREVIOUS PODIATRIST _____ REFERRED BY _____

EMPLOYER _____ OCCUPATION _____

EMERGENCY CONTACT (Name) _____ (Phone) _____

(Relation) _____

IN YOUR OWN WORDS DESCRIBE YOUR FOOT AND/OR ANKLE PROBLEM

_____

_____

_____

PARENT/GUARDIAN INFORMATION (IF PATIENT IS A MINOR)

NAME _____ SSN _____ - ____ - _____
First Middle Last Social Security Number

ADDRESS _____
Street City State Zip

TELEPHONE (Home) _____ (Mobile) _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:_____

MEMBER ID #_____ GROUP #_____

SUBSCRIBERS NAME_____ SUBSCRIBERS DATE OF BIRTH_____

SECONDARY INSURANCE COMPANY:_____

MEMBER ID #_____ GROUP #_____

SUBSCRIBERS NAME_____ SUBSCRIBERS DATE OF BIRTH_____

RELEASE OF BENEFITS AND INFORMATION

I authorize Alderwood Ankle and Foot Clinic, P.S to leave a detailed message if I do not answer my phone.

Initial:_____

I authorize Alderwood Ankle and Foot Clinic, PS. to release information to _____
and understand I can revoke this decision at any time. E.g.: Family Member, Friend, and/or Non-Referring Provider

Regarding: Scheduling Appointments ☐ Discuss Billing and Payments ☐ Patient Notes ☐ Lab Results ☐

Initial:_____

I authorize my insurance benefits to be paid directly to the doctor. I am financially responsible for any balance due. I authorize the doctor or any insurance company to release information required for this claim.

Initial:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I read (or had the opportunity to read if I so choose) and understand the notice.

Initial: _____

OFFICE POLICY

While this office makes every attempt to maintain up-to-date information about your health plan coverage, we require our patients to make inquiry about covered services directly from their health plan's customer service department to avoid any misinterpretations or updates. Please refer to your insurance card for the correct phone number.

Please note that any services done determined medically necessary for your condition are done so by your attending physician in his/her professional judgment. These services may, however, be deemed "non-covered" by your health plan. Our practice administrator will be happy to arrange mutually agreeable self-payment arrangements for these services upon your request.

We will gladly bill your primary and secondary insurance companies. After hearing from primary/secondary insurance, you will be billed with your patient balance. At that time, a payment in full or the amount agreed upon in your payment plan is due.

Initial: _____

I HAVE READ AND AGREE TO ALL OF THE ABOVE

SIGNATURE _____ **DATE** _____

If applicable
PARENT/AUTHORIZED REPRENTATIVE _____ **DATE** _____