

Kansas City Foot Specialist, PA

Dr. David B Laha, D.P.M
Dr. Jennifer G. Phillips, D.P.M
Dr. Andrew M. Hall, D.P.M

Patient Information

Name: _____ Age: _____ Today's Date: _____
Last First Middle

Patients Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Sex: () Male () Female Date of Birth: _____ Social Security #: _____ - _____ - _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail Address: _____

If you would like to become web enabled so you can view your account on line and receive appointment reminders via email please supply email address.

() Decline web Enable

Pharmacy Name and Location: _____

Emergency Contact Name: _____ Relationship _____ Phone# _____

Check One: () Single () Married () Divorced () Widowed () Student () Child

Responsible Party's Name And Employed By: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Employer's Phone#: _____

Spouse/Parent: _____ Date of Birth: _____

Social Security#: _____ - _____ - _____ Employer: _____

Employer's Address _____

City: _____ State: _____ Zip: _____

Employer's Phone#: _____

Primary Care Physician: _____ Date of Last Visit: _____

Referring Physician: _____

If your physician did not refer you to us, how did you hear about our office?

() Friend () Yellow Pages _____ () News Article
() Internet: _____ () Other _____

Advanced Directives: () DNR () Living Will () Organ Donor () No Advanced Directive

If a copy of your Advanced Directive is not obtained at the time of your appointment your requests will not be implemented until there is a copy in your chart.

Patient Name: _____ Patient Signature: _____ Date: _____

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To be compliant with the Government Regulations we need to update your information.

Name: _____ **Date of Birth** _____ **Age** _____

Race:

- | | |
|--|--|
| <input type="checkbox"/> American Indian | <input type="checkbox"/> Native Hawaiian or Pacific Islander |
| <input type="checkbox"/> Alaska Native | <input type="checkbox"/> White or Caucasian |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Other |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Hispanic |
| <input type="checkbox"/> Refuse | |

Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino
- Refuse

Language: English
 Other

Preferred Time To Call:

Morning Afternoon Evening

(2)
Medical History

Patient Name: _____ Date of Birth: _____ Age: _____

Please describe reason for visit: _____

Have you been treated for this problem? () Yes () No If yes, what has been done?

Have you had any previous foot care? () Yes () No If yes, what have you had done and by whom?

Medication: (Please list all medication, vitamins, or supplements) () NONE

Name Diagnoses Name Diagnoses

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies: Are you allergic to any of the below? Please check () NONE

____ Penicillin ____ Sulfa Drugs ____ Tetracycline ____ Aspirin
____ Novocain ____ Cortisone ____ Adhesive Tape ____ Codeine
____ Iodine Dye ____ Caffeine ____ Tape

Other: _____

Surgeries/Hospitalizations () NONE

Personal Social History () NONE

Tobacco: _____ packs per day for _____ years. () current or () former

When did you start smoking? _____

How soon after you wake do you smoke your first cigarette? _____

Are you interested in quitting smoking? _____

Do you currently use chewing tobacco? _____ If so how much daily? _____

Alcohol: _____ oz per week. Caffeine: _____ cups per day.

Fitness activities: _____ How much per week: _____

General Health:

Height: _____ Weight: _____ Shoe Size: _____

Occupation: _____

Women, are you pregnant? () Yes () No If yes, due date _____

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Patient Name: _____ Date of Birth: _____

Patient/Family Medical History:

Have any Blood Relatives Ever Had the Following? () **NONE**

Self	Father	Mother	Sibling	
_____	_____	_____	_____	Anemia
_____	_____	_____	_____	Arthritis (type) _____
_____	_____	_____	_____	Asthma
_____	_____	_____	_____	Breathing Problems
_____	_____	_____	_____	Congestive Heart Failure
_____	_____	_____	_____	Diabetes
_____	_____	_____	_____	Glaucoma
_____	_____	_____	_____	Gout
_____	_____	_____	_____	Hemophilia (bleeding disorders)
_____	_____	_____	_____	HIV positive
_____	_____	_____	_____	Hypertension (high blood pressure)
_____	_____	_____	_____	Liver Disease
_____	_____	_____	_____	Neuropathy
_____	_____	_____	_____	Slow Healer
_____	_____	_____	_____	Stomach Problems
_____	_____	_____	_____	Renal Disease (kidney problems)
_____	_____	_____	_____	Phlebitis (blood clots)
_____	_____	_____	_____	other: Please state

Previous Transfusion (if yes, when): _____

Mother Father Siblings

Alive
Deceased
Unknown

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I, _____ give consent to Kansas City Foot Specialist to *disclose or discuss detailed medical information and/or billing information* with the following person or persons.

Please mark all that apply:

Please list name and phone number below.

Spouse: _____

Father: _____

Mother: _____

Daughter: _____

Son: _____

Sister: _____

Brother: _____

Other: _____

Effective: _____

This form will be valid until we are informed of changes.

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Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Consent for Treatment

I consent to such diagnostic procedures and medical care as deemed necessary by the doctor for my treatment. I also consent to photographs taken which will be used solely for medical education.

Financial Responsibility

I understand that I am responsible for any charges incurred during any visit or treatment by David B. Laha, D.P.M. or Jennifer G. Phillips, D.P.M. or Andrew M. Hall, D.P.M/ Kansas City Foot Specialists, P.A. My insurance may not cover my charges for reasons including, but not limited to, the following: I did not bring a referral for this care, the referral did not arrive in time for the visit, my insurance company does not cover the service, my insurance is not in effect, or charges have been applied to my deductible/co-payment. I understand that I am responsible for a \$40 charge for each returned check or credit card decline. ***Kansas City Foot Specialists will file my insurance when appropriate, but I will be ultimately responsible for all charges.***

I understand that payment is due at the time of service for uninsured patients and for any non-covered services.

I understand that my credit/debit card will be kept on file for payment of services, past and future, that are not covered and/or my responsibility as assigned to me by my insurance company. This credit information is converted to a token (your actual number is not kept) and is stored securely by our bank's system offsite. I understand, and give permission for my credit card to be used for this purpose. A statement will be sent to you prior to your card being charged.

I understand that I will be responsible for a fee of \$75 for any missed appointment which I did not cancel at least 24 hours in advance.

Name of Patient

Signature of Financially Responsible Party

Date

Name of Financially Responsible Party **(please print)**