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:
( ) American Indian
( ) Alaska Native
( ) Asian
( ) Black or African American
( ) Refuse
( ) Native Hawaiian or Pacific Islander
( ) White or Caucasian
( ) Other
( ) Hispanic

Ethnicity:
( ) Hispanic or Latino
( ) Not Hispanic or Latino
( ) Refuse

Language: ( ) English
( ) Other

Preferred Time To Call:
( ) Morning ( ) Afternoon ( ) Evening

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

The above information is correct to the best of my knowledge and 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., 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. *Kansas City Foot Specialists will file my insurance when appropriate, but I will be ultimately responsible for all charges.*

I understand that as a patient of Kansas City Foot Specialists, if I decide to have surgical intervention at the Surgery Center of Blue Valley I will have two separate accounts. I understand if one account has a negative balance and one has a positive balance, the positive balance will be applied to the other account to bring the account to current. Any credit remaining will be issued in the form of check.

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 by our bank's system offsite.

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.

_____ _____
Signature Date

_____
Patient Name **(please print)**

_____
Parent or Authorized Representative (if applicable)