Kansas City Foot Specialist, PA
Andrew Hall, DPM
Megan Kingston, D.P.M

Patient Information

Name:_____ _____Today's Date:_____
Last First Middle Age:
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 online 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 ( ) Google

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:_____

Kansas City Foot Specialists, PA
Dr. David B. Laha, D.P.M Dr.
Dr. Andrew M. Hall, D.P.M

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 medications and why they are taken) **( ) NONE**

Name	Use	Name	Use

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

_____ Penicillin ____Sulfa Drugs _____Tetracycline _____Aspirin
_____ Novocain ____Cortisone _____Adhesive Tape _____Codeine
_____ Sulfa ____ Caffeine _____Tape _____Iodine Dye
Other: _____

Surgeries/Hospitalizations: ( ) NONE

_____
_____

Personal Social History: ( ) NONE

Tobacco: ____packs per day for____ years. ( ) Current or ( ) Former. When did you start smoking?_____
Do you currently use chewing tobacco?_____If show much daily? _____
Alcohol: How often do you have a drink? ( ) Monthly ( ) Weekly ( ) Daily. Number of drinks _____.
Recreation drug use: ( ) Yes ( ) No

Fitness activities:_____ How much per week: _____

Occupation: _____

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

General Health

Height:_____Weight:_____Shoe Size: ___

Kansas City Foot Specialist, PA
Andrew M. Hall, D.P.M
Megan Kingston, DPM

Patient Name:_____Date of Birth: _____

Patient/Family Medical History:

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

Self	Father	Mother	Sibling	
_____	_____		_____	Arthritis
_____	_____		_____	High Blood Pressure
_____	_____		_____	Heart Disease
_____	_____		_____	Diabetes
_____	_____		_____	Liver Disease
_____	_____		_____	HIV
_____	_____		_____	Neuropathy
_____	_____		_____	Asthma
_____	_____		_____	Glaucoma
_____	_____		_____	Respiratory Problems
_____	_____		_____	Bleeding Disorders
_____	_____		_____	Ulcers
_____	_____		_____	Renal Disease
_____	_____		_____	Blood Clots
_____	_____		_____	Anemia
_____	_____		_____	Thyroid Problems
_____	_____		_____	Slow Healer
_____	_____		_____	CHF
_____	_____		_____	Stomach Problems
_____	_____		_____	Mood Disorder
_____	_____		_____	Sleep Disorder
_____	_____		_____	other:

Previous Transfusion (if yes, when):_____

	Mother	Father	Siblings
Alive	( )	( )	( )
Deceased	( )	( )	( )

Kansas City Foot Specialists, PA
Andrew Hall, D.P.M
Megan Kingston, DPM

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.

Kansas City Foot Specialists, PA

Andrew M. Hall, DPM

Megan Kingston, DPM

Notice of Privacy Practices

I acknowledge that I have been 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 the medical care is 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 Andrew M. Hall, DPM, or Megan Kingston, DPM/Kansas City Foot Specialists, PA. My insurance may not cover my charges for various reasons including but not limited to, the following: I did not have 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 was not in effect at the time of the visit, or charges have been applied to my deductible/coinsurance/copayment. 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 ultimately be responsible for all charges.*

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 (the 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)