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 DIPLOMATES, AMERICAN BOARD OF PODIATRIC SURGERY, CERTIFIED IN FOOT SURGERY

MISSOURI: 1956 Copper Oaks Circle Blue Springs, MO 64015 816.228.6995
KANSAS: 9119 W. 74th St., Ste. 352 Shawnee, KS 66206 913.677.3600
 153 W. 151st St., Ste. 120 Olathe, KS 66061 913.829.6800

PATIENT INFORMATION

Last Name _____ First Name _____ M.I. _____ Nickname _____

Birth Date ____/____/____ Age _____ Soc. Sec. # _____ - _____ - _____ Sex: Male Female

Address _____ City _____ State _____ Zip _____

Primary Number (____) _____ - _____ Home Cell Work

Secondary Number (____) _____ - _____ Home Cell Work

Employer _____ Occupation _____

Email Address: _____

Marital Status: Married Single Widowed Divorced Other

I give my consent to the physician and staff at Foot Specialists of Kansas City, P.A. to leave messages or discuss scheduling, treatment, surgery, lab, radiology results or other information regarding my care at the following: Home Cell Work Email None

This information is collected for the government and is optional.

RACE:	ETHNICITY:
<input type="checkbox"/> Black/African American	<input type="checkbox"/> Hispanic/Latino
<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Non-Hispanic/Latino
<input type="checkbox"/> Asian	<input type="checkbox"/> Unknown/Refuse
<input type="checkbox"/> Native Hawaiian/Pacific Islander	LANGUAGE:
<input type="checkbox"/> White	<input type="checkbox"/> English
<input type="checkbox"/> Unknown/Refuse	<input type="checkbox"/> Spanish
	<input type="checkbox"/> Other _____

Primary Physician _____ FIRST NAME _____ LAST NAME _____ Phone Number (____) _____ - _____

Referring Physician _____ FIRST NAME _____ LAST NAME _____ Phone Number (____) _____ - _____

How did you hear about our office? _____

Is this visit related to an accident? Yes No Date of Accident ____/____/____ At Work? Yes No

PRIMARY INSURANCE INFORMATION I do not have medical insurance

Ins.Co.Name _____ ID# _____ Suffix# _____ Group# _____

Name of Policy Holder (if other than self) _____ Policy Holder's DOB ____/____/____

SECONDARY INSURANCE INFORMATION I do not have a secondary insurance

Ins.Co.Name _____ ID# _____ Suffix# _____ Group# _____

Name of Policy Holder (if other than self) _____ Policy Holder's DOB ____/____/____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT? Self (if self leave blank) Spouse Parent Other

Name _____ SSN# _____ - _____ - _____ BirthDate ____/____/____

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ - _____ Cell Phone (____) _____ - _____ Employer _____

PHARMACY INFORMATION I do not have a pharmacy

Pharmacy Name _____ Cross-Streets _____ Phone (____) _____ - _____

Name _____ DOB ____/____/____ Date ____/____/____



MAIN FOOT COMPLAINT: _____

When did this problem first start? _____

PATIENT MEDICAL HISTORY (PAST AND PRESENT) No Medical History

<input type="checkbox"/> Alzheimer's/Dementia	<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Phlebitis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Polio
<input type="checkbox"/> Anxiety/Depression	<input type="checkbox"/> Heart Disease <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Heart Attack	<input type="checkbox"/> Poor Circulation
<input type="checkbox"/> Arthritis <input type="checkbox"/> Rheumatoid <input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> Psychiatric Conditions
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hernia	<input type="checkbox"/> PVD/PAD
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Restless Leg Syndrome
<input type="checkbox"/> Cancer History <input type="checkbox"/> Bone <input type="checkbox"/> Brain <input type="checkbox"/> Breast <input type="checkbox"/> Lung <input type="checkbox"/> Pancreatic <input type="checkbox"/> Prostate <input type="checkbox"/> Skin	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Diabetes <input type="checkbox"/> Insulin <input type="checkbox"/> Non-insulin	<input type="checkbox"/> Hypertension (High Blood Pressure)	<input type="checkbox"/> Skin Problems
<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Kidney Problems/ Dialysis	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> GERD/Acid Reflux	<input type="checkbox"/> Lung Disease <input type="checkbox"/> Bronchitis <input type="checkbox"/> COPD <input type="checkbox"/> Emphysema	<input type="checkbox"/> Swelling (Ankle/Foot)
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Muscle Disease	<input type="checkbox"/> Thrombophlebitis/ blood clots
<input type="checkbox"/> Gout	<input type="checkbox"/> Nerve Disorder	<input type="checkbox"/> Thyroid Disorder
	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Ulcer (GI)
	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Varicose Veins
		<input type="checkbox"/> Vascular Disease
		Other Medical History: _____ _____ _____ _____

SURGICAL HISTORY

No Surgical History

Surgery Name

Year

FAMILY HISTORY

Indicate which family member and whether maternal or paternal. No Family History Adopted

Arthritis _____
Cancer(indicate what type) _____

Diabetes _____
Heart Disease _____
Hypertension _____
Stroke _____
Other _____

Name _____ DOB ____/____/____ Date ____/____/____



SOCIAL HISTORY

- No Social History
- Alcohol. How Often? _____
- Tobacco. How Often? _____
- Illegal Drugs. How Often? _____

MEDICATIONS (List names only. Include over the counter medications and supplements.)

- No Medications
- _____
- _____
- _____
- _____
- _____
- _____

DRUG ALLERGIES No Known Drug Allergies

<input type="checkbox"/> Penicillin	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Other Anti-inflammatory Medications (NSAIDs): _____	<input type="checkbox"/> Local Anesthetics
<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Codeine		<input type="checkbox"/> General Anesthetics
<input type="checkbox"/> Other Antibiotics: _____	<input type="checkbox"/> Other Pain Meds: _____		<input type="checkbox"/> Latex
Other Medication Allergies:			<input type="checkbox"/> Iodine/Shellfish
			<input type="checkbox"/> Tape

ADDITIONAL INFO?

Is there any additional health information you feel like the doctor needs to know? _____

RELEASE OF MEDICAL INFORMATION & EMERGENCY CONTACTS

Dear Patient, in order to protect your confidentiality and to comply with government regulations (HIPAA), Foot Specialists of Kansas City, P.A. is required to obtain authorization from you in order to release messages, and/or provide information regarding your care with any person(s) **other than yourself** (e.g. spouse, children, parents, friends, doctor).

The physician and staff at Foot Specialists of Kansas City, P.A. may discuss my medical information and/or care with the following:

1. Name _____ Emergency Contact
Relationship _____ Phone Number (_____) _____ - _____
2. Name _____ Emergency Contact
Relationship _____ Phone Number (_____) _____ - _____
3. Name _____ Emergency Contact
Relationship _____ Phone Number (_____) _____ - _____



CONFIDENTIALITY NOTICE

I, _____, have received a copy of the HIPAA Notice of Patient Privacy Practices and Patient Financial Responsibility Policy. If requested, it has been explained to me. I also understand that my signature will be stored electronically along with the rest of my medical records.

Signature

_____/_____/_____
DOB

Parent/Guardian Signature (if applicable)

_____/_____/_____
Date