PODIATRY ASSOCIATES
FOOT CARE SPECIALISTS
Diplomates, American Board of Podiatric Surgery

Kansas
8901 West 74th Street, Ste. 200
Shawnee Mission, KS 66204

Missouri
1004 Carondelet Drive, Ste. 480
Kansas City, MO 64114

Dr. Michael Nachlas ◆ Dr. Todd VanWyngarden ◆ Dr. Mitchell Dorris ◆ Dr. Holly Korges

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 Employer _____

Secondary Number (____) _____-_____ ☐ Home ☐ Cell ☐ Work Occupation _____

Email Address _____

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other

In Case of Emergency Call: _____ Number (____) _____-_____

Insurance Information

☐ I do not have medical insurance

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

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

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

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

Patient Consent for Release of Medical Information

Dear Patient, In order to protect your confidentiality and to comply with government regulations (HIPAA), Podiatry Associates 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.

RELEASE OF MEDICAL INFORMATION: The physician and staff at Podiatry Associates may discuss my medical information and/or care with the following: *(Example: Relative, Friend, Spouse)*

Name _____ Relationship _____

MESSAGES: I give my consent to the physicians and staff of Podiatry Associates to leave messages or discuss scheduling, treatment, surgery, lab, radiology results or other information regarding my care as follows:

- ☐ On an answering machine or voice mail at home
- ☐ On an answering machine or voice mail at work
- ☐ Cell Phone
- ☐ I do not consent to messages being left at home, work or with any other person.

I certify that I have insurance coverage with the company(s) listed in the previous section of this form. I assign directly to Podiatry Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges paid or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Signature _____ Date _____

Patient Name _____ DOB _____ Date _____

Medical History (place a mark on "yes" or "no" to indicate if you have had any of the following)

AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Rash	☐ Yes ☐ No
Allergies to Anesthetics	☐ Yes ☐ No	Eye Problems	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Allergies to Medicine or Drugs	☐ Yes ☐ No	Fainting	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Foot or Leg Cramps	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Sinus Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Artificial Heart Valves or Joints	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Swelling in Ankles or Feet	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Hepatitis or Jaundice	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Tired Feet	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Chest Pain	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Varicose Veins	☐ Yes ☐ No
Chronic Diarrhea	☐ Yes ☐ No	Neuropathy	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Phlebitis	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
Ear Problems	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No		

Surgical History

☐ No Surgical History

Surgery Name _____ Year _____ Surgery Name _____ Year _____

_____ _____

_____ _____

Hospitalization (other than surgeries listed)

☐ No Hospitalizations

Hospitalization _____ Year _____ Hospitalization _____ Year _____

_____ _____

Physician Information

Primary Physician _____ Date of Last Visit _____
First Name Last Name

Referring Physician _____ Phone Number (_____) _____-_____
First Name Last Name

How did you hear about our office? _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

Patient Name _____ DOB _____ Date _____

Medications

(Include over the counter and supplements) ☐ Not taking any medications

Name Dosage Frequency

_____

_____

Pharmacy Information

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

Drug & Medication Allergies

☐ No Known Drug Allergies

☐ Adhesive/Tape	☐ Iodine	☐ Novocane
☐ Anticoagulant Therapy	☐ Other Anti-Inflammatory Medications (NSAIDS)	☐ Seafoods
☐ Aspirin	☐ Local Anesthetics	☐ Sulfa
☐ Codeine	☐ Penecillin	☐ Other _____
☐ Demerol		_____

Podiatric History

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

_____

_____

_____

Have you ever been to a Podiatrist before? ☐ Yes ☐ No

If yes, please list.

Name _____

Last Visit _____

Is there any personal or family history of diabetes? ☐ Yes ☐ No

Your occupation _____

Cigarette/Tobacco Use

Years smoked _____

Athletic activities in which you participate (please list and indicate frequency)

_____

_____

_____

Please indicate which foot problems you now have or have had in the past:

Ankle Pain	☐ Yes ☐ No
Athlete's Foot	☐ Yes ☐ No
Bunions	☐ Yes ☐ No
Corns and Calluses	☐ Yes ☐ No
Cramps or Numbness in Feet or Legs	☐ Yes ☐ No
Flat Feet	☐ Yes ☐ No
Foot or Leg Cramps	☐ Yes ☐ No
Heel Pain	☐ Yes ☐ No
Ingrown Toenails	☐ Yes ☐ No
Plantar Warts	☐ Yes ☐ No
Swelling in Ankles or Feet	☐ Yes ☐ No
Tired Feet	☐ Yes ☐ No

Main Foot Complaint:

When did this problem start? _____

Is this related to an injury? ☐ Yes ☐ No Date of Injury ____ / ____ / _____ Activity when injured _____

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