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)

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
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 ☐ Anticoagulant Therapy ☐ Aspirin ☐ Codeine ☐ Demerol	☐ Iodine ☐ Other Anti-Inflammatory Medications (NSAIDS) ☐ Local Anesthetics ☐ Penecillin	☐ Novocane ☐ Seafoods ☐ Sulfa ☐ Other ____________ ____________

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:

Problem	Yes	No
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