**Kansas City Foot Specialists, PA**

# Patient Information

Name: _____ Age: _____ Today's Date: _____
Last First Middle

Patient Address: _____ Apt#: _____

City:_____ State: _____ Zip: _____

Sex: ( ) Male ( ) Female Date of Birth: _____ Social Security #: _____-_____-_____

Home Phone: _____Work Phone: _____Cell Phone: _____

Emergency Contact: _____ Emergency Contact Phone #: _____

Check one: ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Student ( ) Child

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Responsible Party Employed By: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Employer's Phone #: _____

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Spouse/Parent: _____ Date of Birth: _____
Social Security #: _____-_____-_____ Employer: _____
Employer's Address: _____
City: _____ State: _____ Zip:_____
Employer's Phone #: _____

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**Insurance Information We need a copy of your insurance card(s)**
Name of Insurance: _____ Do you require a referral: ( ) Yes ( ) No
Name of Secondary Insurance: _____

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Primary Care Physician: _____ Date of Last Visit: _____
Referring Physician: _____
If your physician did not refer you to us, how did your hear about our office?
( ) Friend ( ) Yellow pages _____ ( ) News article
( ) Internet: _____ ( ) Other_____

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**Please Read and Sign**

I understand that I am responsible for any charges incurred during any visit or treatment by David B. Laha, D.P.M. or Jennifer G. Phillips, D.P.M./Kansas City Foot Specialists, PA. My insurance company may not cover my charges for the following reasons: I did not bring a referral for this care, the referral did not arrive in time for the visit, my insurance company may not cover the service, my insurance may not be in effect, the charges may be applied to my deductible/copay. I understand that I am responsible for a $30 charge for each returned check. Dr. Laha/Dr. Phillips will file my insurance when appropriate, but I will be ultimately responsible for all charges.

I understand that payment is due at the time of service with no insurance or for non-covered services and due within 90 days when filed with my insurance company. I understand that late fees and/or interest may be applied to my bill if not paid within the 90-day period.

Signed: _____ Date: _____