

Kansas City Foot Specialists, PA

Dr. David B. Laha, D.P.M
Dr. Jennifer G. Phillips G.P.M
Dr. Ashley I. Marcol, D.P.M

Medical History

Patient Name: _____ Date of Birth: _____ Age: _____

Please describe your foot problems: _____

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, vitamins, or supplements with **dosages**)

Allergies: Are you allergic to any of the below? Please check

____ Penicillin ____ Sulfa Drugs ____ Tetracycline ____ Aspirin
____ Novocain ____ Cortisone ____ Adhesive Tape ____ Codeine
____ Iodine Dye ____ Caffeine ____ Tape

Other: _____

Surgeries/Hospitalizations: (Please List Year and Right or Left when applicable.)

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Medical History Continued

Please check any of the following, which you or your family have been or are being treated.

Self	Father	Mother	Sibling	
___	___	___	___	Anemia
___	___	___	___	Arthritis (type) _____
___	___	___	___	Asthma
___	___	___	___	Breathing Problems
___	___	___	___	Congestive Heart Failure
___	___	___	___	Diabetes
___	___	___	___	Glaucoma
___	___	___	___	Gout
___	___	___	___	Hemophilia (bleeding disorders)
___	___	___	___	HIV positive
___	___	___	___	Hypertension (high blood pressure)
___	___	___	___	Liver Disease
___	___	___	___	Neuropathy
___	___	___	___	Slow Healer
___	___	___	___	Stomach Problems
___	___	___	___	Renal disease (kidney problems)
___	___	___	___	Phlebitis (blood clots)
___	___	___	___	Other: Please state _____
___	Previous Transfusions (If yes, when) :			_____

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

Personal Social History:

Tobacco: _____ packs per day for _____ years.

Alcohol: _____ oz. per week. Caffeine: _____ cups per day.

Fitness activities: _____ How much per week:

General Health

Height: _____ Weight: _____ Shoe Size: _____

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Jennifer G. Phillips, D.P.M.
Ashley I. Marcol, D.P.M.**

Notice of Privacy Practices

I acknowledge that I was 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 medical care as 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 David B. Laha, D.P.M. or Jennifer G. Phillips, D.P.M./Kansas City Foot Specialists, P.A. My insurance may not cover my charges for reasons including, but not limited to, the following: I did not bring 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 is not in effect, or charges have been applied to my deductible/co-payment. I understand that I am responsible for a \$30 charge for each returned check. *Kansas City Foot Specialists 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 for uninsured patients and for any non-covered services. Any amounts not paid by insurance are due within 90 days of the date the insurance claim was filed. I understand that late fees and/or interest may be applied to my bill if not paid within the 90-day period.

I understand that I will be responsible for a fee of \$35 for any missed appointment which I did not cancel at least 24 hours in advance.

Fees for additional services are listed separately on page 5. I acknowledge receipt of this list of fees.

Signature

Date

Patient Name **(please print)**

Parent or Authorized Representative (if applicable)

Kansas City Foot Specialists, P.A.
Schedule of Fees for Additional Services

FMLA or other disability forms, per set	\$15.00
Medical Records, per set	15.00
X-ray copies, per disk	6.00