



Fine Foot Care Center

The information provided is strictly confidential

PATIENT INFORMATION

DATE: _____

Patient Name: _____

Marital Status (please circle): SINGLE MARRIED WIDOWED DIVORCED

Gender (please circle): Male Female

S.S.# _____ - _____ - _____

Birth Date: _____

Age: _____

Address: _____ Home Phone () _____

City/State/Zip: _____ Work Phone () _____

Email Address: _____ Cell Phone () _____

Employers Name: _____ Occupation: _____

Employers Address: _____

RESPONSIBLE PARTY (if other than patient)

Name: _____ S.S.# _____ - _____ - _____

Birth Date: _____

Home Phone () _____

Address: _____ City/State/Zip _____

Employers Name and Address: _____

Credit Card # for billing*: _____ Expiration Date: _____

**Required*

MEDICAL INFORMATION

Family Physician: _____ Last Visit: _____

Address: _____ Phone: () _____

Do you see a specialist (s) regularly?(please circle) Yes No

If yes, please list: _____

EMERGENCY CONTACT NAME _____ PHONE: () _____

RELATIONSHIP TO PATIENT _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

Family Physician _____ Television _____ Newspaper _____

Specialist _____ Internet _____ Yellow Pages _____

Friend/Coworker _____ Insurance Co. _____

Other (Please specify) _____

PLEASE READ AND SIGN REVERSE SIDE OF PAGE FOR INSURANCE PURPOSES

MEDICAL HISTORY

Fine Foot Care Center

Date _____

What brings you in to see us today? _____

Location of problem _____

Nature of Symptoms (description) _____

Duration of Condition (how long has it bothered you?) _____

Onset (did it begin after a specific event?) _____

Does anything make the problem worse? _____

Does anything make it feel better? _____

Treatment to Date _____

Course (has it improved/become worse/ stayed the same?)

Have you ever been to a podiatrist? Y/N Whom _____

When? _____ Reason? _____

PMH – Family Physician _____

Date of last visit _____

Specialty Physician 1. _____

2. _____

3. _____

4. _____

Previous hospitalizations other than for surgery with dates _____

Have you **previously** been treated or are you **currently** being treated for the following conditions (circle all that apply) AIDS/HIV, anemia, anxiety/depression, cancer, chest pain (angina), degenerative arthritis (DJD/OA), asthma, bleeding disorder, blood clot (DVT), chemical dependency, circulatory problems, diabetes, ear problems, epilepsy, fainting, leg cramps, gout, headaches, heart disease, hemophilia, hepatitis, high blood pressure, high cholesterol, kidney disease, liver disease, low blood pressure, phlebitis, skin problems, rheumatoid arthritis, rheumatic fever, shortness of breath, sleep apnea, sinusitis, stroke, swollen glands, tuberculosis, ulcers, varicose veins, venereal disease, weight loss/gain, other _____

PSH – List all previous surgeries with dates _____

ROS – Do you **currently** suffer from any of the following symptoms (circle all that apply) fever, fatigue, visual changes, runny nose, ear pain, cough, shortness of breath, chest pain, heart palpitations, edema, nausea, vomiting, diarrhea, flank pain, constipation, abdominal pain, rectal bleeding, hematuria, urinary frequency, back pain, joint pain, weakness, headache, numbness, dizziness, lightheadedness, fainting, depression, suicidal thoughts, anxiety, insomnia, itching, skin rashes
other _____

SOC – Occupation _____
Do you get regular exercise? – Y/N How? _____
Do you smoke? – Y/N How many cigarettes/packs per day? _____
How long (years)? _____
Do you drink alcohol? – Y/N How many drinks per day/week/month? _____

FAM HX – Do you have a family history of the following...

Thyroid Disorders	Y/N	High Blood Pressure	Y/N
Emphysema	Y/N	Stroke	Y/N
Cancer	Y/N	Asthma	Y/N
Heart Disease	Y/N	Diabetes	Y/N
Other	_____		

MEDS – Please provide a listing with dosage and frequency of all prescription, OTC, vitamins and herbal medications (you do not need to list again if you have provided us with a list) _____

Pharmacy Name(s) _____
Phone Numbers(s) _____

ALLERGIES - (circle all that apply) Meds – aspirin, clindamycin, codeine, demerol, iodine, local anesthetics, penicillins, sulfa Food – peanuts, dairy, gluten, seafood Environment – bee stings, dust, pet dander, pollen, ragweed
Other – _____



FINE FOOT CARE CENTER, P.C.

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PHONE (816) 455-8900 FAX (816) 455-8901

Financial Responsibility Statement

We thank you for choosing FINE FOOT CARE CENTER for your podiatric health care needs. Whether you come to us by referral of another physician, by direction of your insurance company or like many others, by the referral of a friend or relative, we will strive to provide to you the most complete and up-to-date care possible. Below, you will find our office policy regarding payment contracts, insurance filing, co-pays and collections. We hope this information will be helpful and will prevent any misunderstanding in the future. Please do not hesitate to ask any questions which may arise regarding our practice.

- All patients complete a Patient Information Form **once a year**. A current and valid insurance card and a driver's license should be presented at the time of your appointment.
- All fees are due at the time of service.
- We accept three methods of payment: credit card (Master Card and Visa), cash or check. Should your check be returned to us unpaid, there will be a \$25.00 service fee charged to your account and your subsequent visit will be on a "cash only" basis.
- We will be happy to file your insurance for you as a courtesy.
- Anytime during your care with us, we ask that you please notify the reception desk of any changes in your personal information file: insurance, address, telephone numbers, employment, etc. You will be periodically asked to complete a new Patient Information Form.
- Our office requires **24 hours** notice if you are unable to keep your appointment. This courtesy allows us to be of service to other patients. If you have a late "cancellation" (less than 24 hours notice) or fail to show up for a scheduled appointment, a fee of \$40.00 may be assessed. This fee must be paid prior to your next appointment.

HMO Patients

If you have insurance through an HMO, a referral from your Primary Care Physician may be required before you can be seen in our office. This is a requirement of your insurance company, not FINE FOOT CARE CENTER. If needed, this referral must be acquired by the time of your appointment or we will not be able to provide service at that time of your appointment. If required and you do not have a referral and choose to be seen, you will be responsible for paying your fees at the time of your appointment.

PPO Patients

If we are participants of your PPO, we will be happy to file your charges for you. Your co-payment, however, is due at the time of your appointment. It is a requirement that you provide us with a current active insurance ID card each time you visit us.

Account Delinquency

All balances are the responsibility of the patient, and if your insurance has not paid their portion, this becomes your responsibility. Accounts become delinquent after 30 days. The account will be sent to a collection agency after 60 days from the time of the insurance payment, or if the payments drop below the contracted amount at any given time. Collection fees will then be added to your account. All collection accounts must be paid in full before future care at this office will be permitted

We are pleased to have the opportunity to serve you. We will provide services to you and will do our best to file your claim in a timely and professional manner. If you have any questions or concerns regarding our billing and collection policies, please ask. Again, thank you for allowing FINE FOOT CARE CENTER to serve you.

Patient _____ Date _____