Foot Doctors of KC
Robert Bondi, DPM - Laurel Bondi, DPM – Ann Hanon, DPM
Patient Information

Patient Name:_____ **Today's Date:**_____
First Middle Last

Patient Address:_____

City:_____ **State:**_____ **Zip Code**:_____

Home Phone:_____ **Work#:**_____ **Cell#**:_____

Date of Birth:_____ **Social Security#**_____-_____-_____ **Gender:** ☐ Male ☐ Female

Check all that apply: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Fulltime Student

Race: (Please check one) ☐ Asian ☐ Black or African American ☐ Hispanic ☐ White ☐ Other Race
☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander

Primary Language Spoken:_____ **Name of Employer** (If a minor, parent's employer): _____

Your email address: _____

If patient is a minor, name of parent/guardian accompanying child today:_____
***Please note: We cannot bill your ex-spouse unless you present a court order to our office stating they are responsible.**

*Insurance Information:

Name of ***Primary*** Insurance Co:_____
Are you the policy holder? ☐ Yes ☐ No
Policy holder's date of birth:_____ Policy holder's SS#:_____-_____-_____

Name of ***Secondary*** Insurance Co:_____

Do you have an Advance Directive Plan ☐ Yes ☐ No

Name of your Primary Care Physician:_____
Are you under your physician's care for any medical reasons? ☐ Yes ☐ No

Emergency Contact Name:_____
Phone Number:_____ **Relationship:**_____

How did you hear about our office? ☐ My Primary Doctor ☐ Yellow Pages ☐ Insurance Company
☐ Google/Yahoo ☐ Other Internet ☐ Another doctor:_____ ☐ Other _____
☐ Another patient (please include their name) _____

Please read and sign below:

*I certify that I have insurance coverage with the company(ies) listed above. I assign directly to Dr. Robert Bondi, Dr. Laurel Bondi and Dr. Ann Hanon all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions and claims. I understand that I am financially responsible for all charges whether or not paid by insurance.

The above named doctor(s) may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

To insure the continuity of care, I also authorize Dr. Robert Bondi, Dr. Laurel Bondi and Dr. Ann Hanon to provide the information regarding my treatment and any medication I received at this office to my primary care physician.

Signed:_____ **Date:**_____
(Patient *or* Parent/Legal Guardian)