Foot Doctors of KC
Robert Bondi, DPM - Laurel Bondi, DPM – Raquel Sugino, 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:_____
Policy holder's date of birth:_____ Policy holder's SS#:_____-_____-_____

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

PHARMACY NAME AND LOCATION: _____
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 and Dr. Laurel Bondi 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. Raquel sugino 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)

PATIENT MEDICAL INFORMATION

Name _____ **Date**_____ **Birth Date** _____

Shoe Size _____ **Height** _____ **Weight** _____ **Age**_____

What is your main foot complaint?_____

When did this problem first start? _____

Type of Pain: (*check all that apply*) ☐Sharp ☐Dull ☐Burning ☐Numbness ☐Throbbing ☐Radiating ☐General ☐Local

What eases pain? _____

What makes pain worse? _____

What have you done to help this problem? _____

If another doctor treated you for this problem, what was done? _____

_____

Medications:

What are your current medications? (List may be attached) _____

_____

Please check any of the following you are currently taking:

☐Echinacea ☐Garlic ☐Ginger ☐Gingko Biloba ☐St. John's Wort ☐Ephedra
☐Kava kava ☐Feverfew ☐ Hoodia ☐Any other weight loss pills _____

Previous Surgeries: **Date:**

_____ _____
_____ _____
_____ _____
_____ _____

Please note any complications: _____

_____

Do you have any implanted metal devices? (e.g. pacemaker, stent, etc.)

☐ **NO** ☐ **YES (please list)** _____ **Date of implant:**_____

Immunization Status: Tetanus: ☐Current ☐Over 5 years ☐Over 10 years ☐Unknown

Flu Shot: ☐ Yes ☐ No Hepatitis B: (3 doses) ☐Received ☐Never received

Allergies: (Please check any that apply) ☐ I have no known allergies

☐Penicillin ☐Sulfa drugs ☐Other antibiotics (Please specify)_____
☐Aspirin ☐Codeine ☐Other pain medications _____
☐Other anti-inflammatory medications (NSAIDS)_____
☐Local anesthetics ☐General anesthetics ☐Latex ☐Iodine/Shellfish
☐Other medication allergies _____

Medical history: Please check (X) any of the following illnesses you have ever had:

☐ Allergies
☐ Anemia
☐ Anxiety disorder
☐ Arthritis: (Please check)
  ☐Rheumatoid
  ☐Osteoarthritis
☐ Asthma
☐ Bladder dysfunction
☐ Bleeding Disorders
☐ Cancer history: (please check)
  ☐Breast
  ☐Lung
  ☐Prostate
  ☐Bone
  ☐Brain
  ☐Pancreatic
  ☐Skin
☐ Depression

☐ Diabetes: (Please check)
  ☐Insulin
  ☐Non-insulin
☐ Drug abuse
☐ Epilepsy
☐ Eye problems
☐ Fracture history
☐ GERD/acid reflux
☐ Gout
☐ Headaches/Migraines
☐ Hearing problems
☐ Heart disease
☐ Hepatitis ☐A ☐B ☐C
☐ Hernia
☐ HIV/Aids
☐ High Blood Pressure (Hypertension)
☐ High Cholesterol
☐ Kidney problems/Dialysis

☐ Lung disease: (Please check)
  ☐Bronchitis
  ☐Emphysema
  ☐COPD
☐ Muscle disease
☐ Polio
☐ Prostate conditions
☐ Psychiatric conditions
☐ Restless leg syndrome
☐ Skin problems
☐ Sleep Apnea
☐ Stroke
☐ Thrombophlebitis/blood clots
☐ Thyroid disorder
☐ Ulcer (GI)
☐ Varicose veins

Please list any other conditions you have that are not listed above:_____

Social History:

Alcohol Use: Do you drink ☐ Daily ☐ Weekly ☐ Monthly? How many drinks _____ How often do you have 6 or more drinks
at one time ☐ Daily ☐ Weekly ☐ Monthly? ☐ I do not drink alcohol

Tobacco Use: ☐Everyday ☐Sometimes (but not every day) ☐ **I do not smoke or use tobacco**
How many cigarettes in a day ☐5 or less ☐6-10 ☐11-20 ☐ 21-30 ☐31 or more

How long after you wake up do you have your 1st cigarette ☐within 5 min ☐6-30min ☐31-60 min
Are you interested in quitting: ☐yes ☐No

Marital Status_____
Employment status: ☐ Full-time ☐ Part-time ☐Self-employed ☐Retired ☐Disabled ☐Homemaker ☐Unemployed

Athletic activities:_____

Family Medical History: *Please check the conditions that your Mother or Father have or have had.*

☐ Diabetes	☐ Mother	☐ Father	
☐ Hypertension	☐ Mother	☐ Father	
☐ Heart Disease	☐ Mother	☐ Father	
☐ DVT	☐ Mother	☐ Father	
☐ Cancer	☐ Mother	☐ Father	
☐ Stroke	☐ Mother	☐ Father	
☐ Mental Illness	☐ Mother	☐ Father	☐ **I do not know any of my family history (adopted)**

Mother ☐Alive ☐Deceased
Father ☐Alive ☐Deceased

Patient Signature _____ **Date** _____
(If a minor, Parent or Guardian Signature)

Dear Patient,

In order to protect your confidentiality and to comply with government regulations (HIPAA), Foot Doctors of KC are 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 physicians and staff at the Foot Doctors of KC office may discuss my medical information and/or care with the following. **(Please check all that apply and list the names.)**

☐ My Spouse (name)_____

☐ Name_____ Relationship_____

☐ Name_____ Relationship_____

MESSAGES:
I give my consent to the physicians and staff of the Foot Doctors of KC office to leave or discuss treatment, surgery, lab, radiology results or other information regarding my care as follows.
(Please check all that apply.)

☐ On answering machine or voice mail at home.

☐ On cell phone

☐ On answering machine or voice mail at work.

☐ Email through Patient Portal

☐ I do not consent to messages being left at home, work, or with any other person.

I hereby acknowledge that I have received Robert Bondi, DPM, Laurel Bondi DPM and Dr. Raquel Sugino Notice of Privacy Practices. (HIPAA)

Patient's Name: _____ Date of Birth:_____
(Please print)

Signature: _____ Today's Date:_____
(Patient sign *or* Parent of a minor)

HIPAA CONSENT TO VIEW HISTORY OF SCRIPTS:

I also give consent to Drs. Robert Bondi, Laurel Bondi and Dr. Raquel Sugino to view my prescription history.

Signature: _____ Today's Date: _____
(Patient sign *or* Parent of a minor)