Foot Doctors of KC
Robert Bondi, DPM - Laurel Bondi, DPM – Raquel Sugino, DPM – John Paul Sevcik, 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): _____

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.**

PHARMACY NAME AND LOCATION: _____

Do you have an Advance Directive Plan ☐ Yes ☐ No

Name of your Primary Care Physician: _____
Name of Referring Provider: _____

Emergency Contact Name:_____

Phone Number:_____ **Relationship:**_____

*Insurance Information:

Name of ***Primary*** Insurance Co: _____ Policy holder's SS# (Tricare) _____

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

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, Dr. Raquel Sugino, and Dr. John Paul Sevcik 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. I understand The Foot Doctors of KC are NOT MEDICAID providers and any balances left from the insurance is my responsibility.**

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 ensure the continuity of care, I also authorize Dr. Robert Bondi, Dr. Laurel Bondi, Dr. Raquel Sugino and Dr. John Paul Sevcik 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 including any vitamins and herbs? (List may be attached)

_____

_____

_____

Flu Shot: ☐ Yes ☐ No

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:** _____

Under Hospice Care: ☐ Yes ☐ No **If yes Medicare #** _____

Skilled/Rehab Facility ☐ Yes ☐ No **Facility Name**_____ Date entered_____

Allergies: (Please list all <u>medication</u> and <u>anesthetic</u> allergies including Iodine) _____

_____

☐ **I have no known allergies**

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

☐ Allergies/Seasonal
☐ Anemia
☐ Anxiety/depression
☐ Arthritis: (Please check)
  ☐ Rheumatoid
  ☐ Osteoarthritis
☐ Asthma
☐ Bladder dysfunction
☐ Bleeding Disorders
☐ Cancer history:

_____

☐ Dementia/Alzheimer
☐ 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/breathing issues

_____

☐ 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_____?
☐ I do not drink alcohol
How often do you have 6 or more drinks at one time ☐ Daily ☐ Weekly ☐ Monthly ☐ Never

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

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	

Mother ☐Alive ☐Deceased
Father ☐Alive ☐Deceased

☐ **I do not know any of my family history (adopted)**

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, Dr. Raquel Sugino and John Paul Sevcik, DPM 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, Dr. Raquel Sugino and John Paul Sevcik to view my prescription history.

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