Kansas City Institute of Podiatry

Dr. Jeffrey Roith, Dr. Sarah Russell & Dr. Jason Burkle
10550 Quivira Road, Suite 360
Overland Park, KS 66215

Name: _____ Date of Birth: _____

Primary Care Physician: _____ Date Last Seen: _____

Height: _____ Weight: _____ Shoe Size: _____

Chief Concern

Reason for today's visit? _____

Is your current problem due to an injury? If so, when and where? _____

How long has this problem been present? _____

From 1 to 10 what is the level of your pain? (1 is low, 10 is high) _____

Does anything improve this problem? _____

Does anything worsen this problem? _____

What treatments have your tried? _____

Have you seen a podiatrist or other physician for this problem? _____

Have you seen a podiatrist for any other problems? If so, what? _____

Medical History

Please **CHECK** any current or past conditions

___ Alcoholism	___ High Cholesterol
___ Anemia	___ HIV/AIDS
___ Anorexia	___ Kidney Disease
___ Appendicitis	___ Liver Disease
___ Arthritis	___ Measles
___ Asthma	___ Migraines
___ Bleeding Disorder	___ Miscarriage
___ Bronchitis	___ Mononucleosis
___ Cancer	___ Multiple Sclerosis
___ Cataracts	___ Mumps
___ Chemical Dependency	___ Pacemaker
___ Chicken Pox	___ Pneumonia
___ CHF	___ Polio
___ Coronary Disease	___ Prostate Problem
___ COPD	___ Psychiatric Care
___ Dementia	___ Rheumatic Fever
___ Diabetes	___ Scarlet Fever
___ Emphysema	___ Seizures
___ Epilepsy	___ Stroke
___ Gout	___ Suicide Attempt
___ Heart Attack	___ Thyroid Problems
___ Heart Disease	___ Tonsillitis
___ Hepatitis	___ Tuberculosis
___ Hernia	___ Typhoid Fever
___ High Blood Pressure	___ Ulcers

Medication List

Please list **ALL** medications: Prescribed, Over-the-Counter, Vitamins and/or Supplements **OR** attach medication list

Medication Name	Dosage	Frequency

Allergies/Sensitivities

Please list **ALL** allergies/sensitivities and reaction to each

Allergy To	Reaction

Surgical History & Hospitalizations

Year	Procedure and/or Reason

Social History

Please CIRCLE and/or ANSWER what applies to you

I am..... SINGLE MARRIED WIDOWED
SEPERATED DIVORCED

I live with _____

Smoker? CURRENT, I smoke _____ pack(s) per day.
FORMER, I quit _____ years ago.
NEVER

Do you drink alcohol? YES, I have _____ drinks per week.
NO

Do you drink caffeine? YES, I have _____ drinks per day.
NO

Do you use any recreational drugs? YES NO

Are you currently employed? YES NO

Do you have children? YES, I have _____ children.
NO

Are you currently pregnant? YES NO

Family History

Does anyone in your family have history of the following? If YES, check and list who (Mother, Father, Siblings, Children)

__ Arthritis: _____
__ Asthma: _____
__ Cancer: _____
__ Chemical Dependency: _____
__ COPD: _____
__ Diabetes: _____
__ Glaucoma: _____
__ Gout: _____
__ Heart Attack: _____
__ Heart Disease: _____
__ High Blood Pressure: _____
__ Kidney Disease: _____
__ Mental Illness: _____
__ Stroke: _____
__ Tuberculosis: _____
__ Other: _____

Review of Systems

Please CHECK any symptom you have currently or had within the past year

Constitutional
__ Recent Fevers/Sweats
__ Unexplained Fatigue/Weakness
__ Unexplained Weight Gain/Loss

Eyes
__ Changes in Vision

Ear, Nose, & Throat
__ Difficulty Hearing
__ Ringing in Ears
__ Allergies
__ Congestion
__ Trouble Swallowing

Respiratory
__ Cough/Wheezing
__ Coughing Up Blood

Urinary
__ Blood in Urine
__ Frequent Urination
__ Lack of Bladder Control
__ Painful Urination

Cardiovascular
__ Blood Clots
__ High Blood Pressure
__ Low Blood Pressure
__ Palpitations
__ Poor Circulation
__ Raynaud's
__ Short of Breath
__ Swelling of Ankles
__ Varicose Veins
__ Venous Insufficiency

Hematologic/Lymphatic
__ Anemia
__ Bleeding Tendency
__ Bruise Easily
__ Swollen Lymph Glands

Gastrointestinal
__ Diarrhea
__ Heartburn/Reflux
__ Nausea
__ Stomach Pain
__ Vomiting

Endocrine
__ Cuts take longer to heal
__ Diabetes Mellitus
__ Extreme Thirst
__ Fatigue
__ Hyperglycemia
__ Hypoglycemia
__ Thyroid Problems

Neurological
__ Dementia
__ Neuropathy
__ Seizures
__ Shingles
__ Tremors

Allergic/Immunologic
__ Asthma Attack
__ Coughing/Sneezing
__ Environmental Allergies
__ Gouty Attack
__ Seasonal Allergies

Skin
__ Bruise Easily
__ Cellulitis
__ Chronic Wounds
__ Eczema
__ Hives
__ Itching
__ Psoriasis
__ Rash

Musculoskeletal
__ Arthritis
__ Fracture: _____
__ Joint Pain: _____
__ Muscle Weakness

Psychiatric
__ Alcohol Addiction
__ Anxiety
__ Depression
__ Paranoia
__ Other: _____

I certify that the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____

Kansas City Institute of Podiatry

JEFFREY T. ROITH, DPM
SARAH E. RUSSELL, DPM
JASON W. BURKLE, DPM

PHONE 913-894-4040
FAX 913-438-4725

PLEASE PRINT AND COMPLETE ALL INFORMATION

PATIENT INFORMATION					
Patient Name (Last, First, Initial)			Home Phone		Cell Phone
Address	Social Security #	DOB	Age	☐Male ☐Female	Marital Status M S D W
City, State, Zip			Email Address		
Employer	Phone #	Primary Care Physician (PCP)			PCP's Phone #
Occupation Business Address		City, State, Zip			

GUARANTOR INFORMATION (Insurance card holder, parent info if patient is a minor, or person responsible for account)		
Name	Relationship	Phone #
Address		Social Security #
City, State, Zip		Occupation
Employer		Phone #
Business Address		City, State, Zip

EMERGENCY CONTACT	
Contact's Name	Relationship to Patient
Home Phone ( )	Work Phone ( )

INSURANCE INFORMATION (We will also need a copy of your insurance card)			
Primary Insurance Company	Name of Insured	Date of Birth	Relationship to Patient
ID #	Group #		SSN of Insured
Secondary Insurance Company	Name of Insured	Date of Birth	Relationship to Patient
ID #	Group #		SSN of Insured

HOW DID YOU BECOME AWARE OF OUR SERVICE?

Referred By:_____ ☐ Ins Co ☐Yellowbook ☐Yellow Pages ☐Website ☐Lifetime Fitness

CONSENT FOR TREATMENT AND FINANCIAL ARRANGEMENTS

I, the undersigned certify that I (or my dependent) have coverage with the above insurance company and assign directly to Jeffrey T. Roith, DPM and or Sarah E. Russell, DPM all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient or Responsible Party Signature	If Not Patient - Relationship	Date

REVISED 8-29-18

Kansas City Institute of Podiatry

JEFFREY T. ROITH, DPM
SARAH E. RUSSELL, DPM JASON W. BURKLE, DPM
Phone: 913-894-4040
Fax: 913-438-4725

THIS FORM IS ABOUT PERMISSION TO SPEAK WITH ANOTHER PARTY REGARDING REMINDER CALLS, MEDICAL RECORDS, BILLING RECORDS, AND NOTICE OF PATIENT CARE UTILIZING PHOTOGRAPHY.

Patient's Name: _____ DOB: _____

REMINDER CALLS:

☐ **Home:** Leave message
- ☐ on answering machine
- ☐ with anyone who answers home phone
- ☐ only with _____(Name)
- ☐ contact patient only _____

☐ **Office:** Leave message
- ☐ on voice mail at work
- ☐ with anyone who answers work phone
- ☐ only with _____(Name)
- ☐ contact patient only _____

☐ **Other:** _____ Phone _____

MEDICAL RECORDS:

I hereby authorize you to discuss my medical treatment with:

_____ Phone _____
(Person or Party you are permitting to receive information)

_____
(Person or Party you are permitting to receive information) Phone _____

_____
(Person or Party you are permitting to receive information) Phone _____

☐ **DO NOT RELEASE OR DISCUSS MEDICAL TREATMENT WITH ANYONE OTHER THAN PATIENT AND/ OR RESPONSIBLE PARTY.**

ACCOUNT INFORMATION

I hereby give permission for the following individuals to discuss my billing/account information:

_____ Phone _____
(Person or Party you are permitting to receive information)

_____
(Person or Party you are permitting to receive information) Phone _____

_____
(Person or Party you are permitting to receive information) Phone _____

☐ **DO NOT RELEASE OR DISCUSS BILLING/ACCOUNT INFORMATION WITH ANYONE OTHER THAN PATIENT AND/ OR RESPONSIBLE PARTY.**

PHOTOGRAPHY DOCUMENTATION

"I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that Jeffrey T. Roith, DPM and Sarah E. Russell, DPM will retain ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law oroutlined in Jeffrey T. Roith, DPM's policy. Images that identifiy me will be released and/or used outside the institution only upon written authorization from me or my legal representative." This consent does not authorize the use of the images for other purposes, such as teaching or publicity. A separate consent for photography form should be used for such purposes.

_____ _____
Signature of Patient or Responsible Party Date

REVISED 1-3-18

Kansas City Institute of Podiatry

JEFFREY T. ROITH, DPM
SARAH E. RUSSELL, DPM
JASON W. BURKLE, DPM

OFFICE FINANCIAL POLICY

This sheet has been prepared for your benefit. It contains information regarding our billing and insurance procedures. If you have any questions regarding the following policies, please feel free to talk to us about them.

Our office operates on a fee for services basis. All co-pays are due at the time of service. We will file all insurance claims. If we are not contracted with your insurance company, all charges including examination, consultation, x-rays and special tests performed in the office are due and payable in full at the time of service. We will accept cash, personal checks, money orders, MasterCard, Visa, and Discover. If other arrangements are necessary please discuss them with our office manager **BEFORE** you see the doctor.

Payment of the doctor's fee is the personal financial obligation of the patient or the person authorizing treatment. This personal obligation is not altered because the patient's charge is covered, in whole or in part, by insurance. **It is your responsibility to know what is and is not covered by your insurance company. It is your responsibility to know whether or not the doctor you are seeing is contracted under your plan.** Full payment is expected within 30 days. Any statement not receiving a payment after 30 days is past due. There will be a $10 monthly late fee and all balances will be assessed a 1% monthly late charge each month on all balances that are not paid within 30 days. There is a $30 fee for any check that is returned for insufficient funds. For those patients requiring a referral from their primary physician, as requested by your insurance company...**please note**...it is **YOUR** responsibility to obtain these before coming in for an office visit and/or surgery. Thank you for your cooperation.

I authorize the release of any medical or other information to my insurance company as they request. I agree that a photographic copy of the authorization is a valid as the original.

I hereby authorize payment of medical benefits directly to **Kansas City Institute of Podiatry, Jeffrey T. Roith, DPM** and/or **Sarah E. Russell, DPM** for the services described on the attached claim form.

I understand that regardless of performance by my insurance company I am responsible for payment of my account. In the event that I should default or my account should become seriously delinquent, I agree to pay all reasonable collection costs including but not limited to attorney fees, agency fees, court costs, and the like.

I, _____, have read the above financial policy and understand my obligation.
Patient's Name (Printed)

Signature:_____ Date _____

OUR POLICY REGARDING RELEASE OF PROTECTED HEALTH INFORMATION

We are more than happy to forward a copy of your medical records to another physician per your request. You must complete an Authorization For Disclosure of Protected Health Information form (available in our office), and a fee may be charged for handling and reproduction. No original X-rays will be released per HIPAA guidelines. However, a quality digital reproduction will be made available upon request. Please provide a reasonable amount of time for copying.

I have read the above release of information policy and understand its content.

Signature: _____ Date _____

REVISED 8-29-18

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Please answer the following questions in order to complete your health record, as required by CMS:

What is your primary language? _____

What is your race?
____ American Indian
____ Asian
____ Black or African American
____ Native Hawaiian or Other Pacific Islander
____ White

What is your ethnicity?
____ Hispanic or Latino
____ Not Hispanic or Latino

Printed name: _____

Signature: _____

Date of Birth: _____ Todays Date: _____