PATIENT INFORMATION (Please Print)

Date_____

Last Name_____

First Name _____ MI____

Address_____

City_____

State _____ Zip_____

Phone (____) _____

E-mail_____

Marital Status S M D W

Date of Birth_____

Sex M F

S.S._____

Chief Complaint_____

PRIMARY PHYSICIAN

_____

Phone #_____

Address_____

City, St, Zip_____

PATIENT EMPLOYMENT

Employer_____

Occupation_____

Address_____

City _____ State___ Zip_____

Phone (____) _____

Insured's I.D._____

ALLERGIES:_____

_____

_____

_____

_____

_____

_____

INSURANCE

Insurance Co._____

Address_____

City _____ State____ Zip_____

Group #_____I.D. #_____

SECONDARY INSURANCE

Insurance Co._____

Group #_____I.D. #_____

Phone (____) _____

RESPONSIBLE PARTY

(Person to be billed or insurance carrier)

Last Name_____ First Name_____

Address_____

City _____State _____Zip_____

Phone (____) _____

Date of Birth_____

S.S._____

RESPONSIBLE PARTY EMPLOYMENT

Employer_____

Occupation_____

City _____ State_____ Zip_____

Address _____

Phone (____) _____

MEDICATIONS/OTC/VITAMINS: _____

_____

_____

_____

_____

_____

_____

_____

Pharmacy name and phone number_____

Family History: Maternal (Mother) / Paternal (Father)

M__ P__ Alcoholism
M__ P__ Anesthesia Problems
M__ P__ Arthritis
M__ P__ Cancer
M__ P__ Cystic Fibroses
M__ P__ Diabetes
M__ P__ Heart Problems
M__ P__ Neurological Disorder
M__ P__ Respiratory
M__ P__ Seizures

PAST MEDICAL HISTORY

Cardiovascular: (Please X if you HAVE HAD these.)

__Congestive heart failure
__Deep Vein Thrombosis
__General Cardiovascular Problems
__High or Low Blood Pressure
__Murmur
__Rheumatic
__Stroke

Childhood Illnesses:

__Asthma
__Chickenpox
__Ear Infection
__Influenza
__Measles
__Mumps

Dermatologic:

__Candidiasis (yeast infection)
__Cellulitis
__STD
__ Itchy Dry Skin
__Keratosis
__Psoriasis
__Fungal Infections
__Raynaud's phenomenon
__Skin Cancer
__Warts

Endocrine:

__Diabetes
__Hypothyroidism
__Hypoglycemia
__Menopause
__Obesity

Genetic Background:

__Autism
__Cystic Fibrosis
__Hemophilia
__Muscular dystrophy

Gastric Intestines:

__Cancer
__Colitis
__Crohn's
__Diverticulitis
__GERD
__Gastritis
__GI bleed
__Liver conditions
__Stomach or bowel problems

GU:

__Bladder dysfunction
__Kidney problems
__Dialysis

Heent Hx:

__Allergic Rhinitis
__Dentures/Partials
__Ear conditions
__Eye conditions
__Nasal conditions
__Throat conditions

Hematological:

__Anemia
__Leukemia
__Hemophilia
__Bleeding abnormalities
__Lymphoma

Musculoskeletal:

__Amputation
__Arthritis
__Fracture history_____
__Ganglion
__Gout
__Neoplasm
__Osteomyeolitis
__Osteoporosis

Neurological History:

__Alzheimer's
__Aneurysm
__Migraines
__Multiple Sclerosis
__Neurofibromatosis
__Neuropathy
__Seizure Disorder
__Sciatica

Psychiatric:

__Alcoholism
__Dementia
__Depression
__Drug abuse

Respiratory:

__Asthma
__COPD
__Emphysema
__Lung Cancer
__Pneumonia
__Tuberculosis

Review of Systems (Please X if you HAVE these.)

Allergic/Immunologic

__seasonal allergies __sensitivity to dust
__coughing

Constitutional Symptoms

__sleep problems __fever
__dizziness __headache
__faintness

Endocrine

__dry hair __cold intolerance
__weight changes

Gastrointestinal

__abdominal pain __heartburn
__blood in stool

Hematologic/Lymphatic

__ankle/foot edema __calf pain
__bruise easily __bleeding problems

Musculoskeletal

__back pain __joint swelling
__heel pain __muscle pain
__hip pain __neck pain
__joint pain __stiffness

Respiratory

__difficulty breathing __shortness of breath
__chest tightness
__snoring

Cardiovascular

__arm pain __high blood pressure
__chest pain __chest pressure
__cold hands __cold feet
__calf cramping

Ear, Nose, Mouth, Throat

__hearing loss __sore throat
__blisters in mouth __sinus problem

Eyes

__dry eyes __itchy eyes
__excess tearing __glaucoma
__macular degeneration

Genitourinary

__currently pregnant __painful urination
__on dialysys

Integumentary

__athletes foot __discoloration
__cyst __leg swelling
__dry, scaly skin __lower leg ulcers

Neurological

__dizziness __ migraines
__confusion __seizures
__forgetfulness __tingling
__headache __tremors

Past Surgical History (type of surgery and year surgery was performed)

_____

_____

_____

Social History

Do you smoke? _____Yes _____No How Much_____ How Long_____

Do you drink alcohol? _____Yes _____No How Much_____ How Long_____

What type of job do you have? _____

Patient Checklist

Please mark the activities that you are not able to perform due to your foot condition.

_____ Walking _____ more than 1 block, _____ more than 5 blocks, _____ more than 10

_____ Running _____ Yard work _____ Exercise

_____ Jogging _____ Housework _____ Work

_____ Driving _____ Yoga _____ Shopping

_____ Climbing stairs _____ Swimming

Where is your pain located specifically?

_____ In the Bump

_____ In the Toes _____ With motion in the Bump area

_____ In the Joint _____ Without motion in the Bump area

_____ With shoes on _____ With motion of the Joint

_____ With shoes off _____ Without motion of the Joint

Where did you hear about our service from? (Please circle one) Yellow Pages Internet

Friend Newspaper TV Radio Family Health-fair Dr. Referral_____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge and I consent to such diagnostic procedures and medical care as deemed necessary by the doctor for my treatment. I also consent to having photographs taken which will be used solely for the purpose of medical education.

_____ _____

Patient/Parent/Guardian Date

AUTHORIZATION FOR TREATMENT & RELEASE OF INFORMATION

FOR PODIATRY SERVICE

I, _____; the resident, legal guardian or health care surrogate, hereby authorize Central Kansas Podiatry Associates doctors and staff to examine and treat the afore mentioned, if necessary:
I understand that this consent may be withdrawn at any time and withdrawal of consent must be in writing to the Central Kansas Podiatry Associates doctors and staff. The resident, legal guardian or health care surrogate authorizes Central Kansas Podiatry Associates doctors and staff to disclose appropriate and necessary clinical information to other facility staff for the purpose of treatment. Clinical information can be released to family members listed below for purposes of treatment:
1._____
2._____
3._____
4._____
The resident, legal guardian or health care surrogate, if any, has READ and has had fully explained to him/her, and fully understands the above Authorization for Treatment. No assurance or guarantee has been made to the resident, legal guardian, or health care surrogate, if any, concerning the results, which may be obtained.

CLINICAL RESEARCH DISCLOSURE AND CONSENT FOR CONTACT

Your Central Kansas Podiatry Associates Health Care provider may from time to time determine that you would be an appropriate candidate for inclusion in a clinical research study. These studies are typically coordinated by the Professional Research Network of Kansas but other research firms may also coordinate studies that include patients of Central Kansas Podiatry Associates. You are not required to participate in any way in any clinical research study and your refusal to participate will not affect your relationship with Central Kansas Podiatry Associates. By consenting below you agree only that Central Kansas Podiatry Associates may provide your name to the Professional Research Network of Kansas or other clinical research firm as a potential candidate for study participation and they may contact you to discuss participation in a study. If you do not wish to participate when contacted by the research firm you will inform them that you do not wish to participate. Central Kansas Podiatry Associates and any research firm that we may authorize to contact you are required to protect your health information according to the applicable laws and regulations including HIPAA.

_____agree to permit Central Kansas Podiatry Associates to allow a clinical research firm to contact me regarding possible participation in a clinical research study. I may refuse to participate at the time that I am contacted by the research firm.

_____do not wish to be contacted regarding possible participation in a clinical research study.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

_____ _____
Patient Name (Please Print) Date

_____
Parent or Authorized Representative (if applicable)

_____
Signature

BILLING POLICY

REGARDING HMO'S, PPO'S and MANAGED CARE PROGRAMS:
We do not participate in some of these programs, so please check with your insurance company to see if we are providers for your particular plan. It is your responsibility to obtain all referral forms required by your insurance company. Please be aware that if you are seen by our doctor under an out of network insurance plan, you assume liability for the difference in coverage benefits. Some HMO/PPO/Managed Care Primary Care Physicians require all x-rays to be taken at their office so please check with your physician before your appointment.

COPAYS:
You will be expected to pay your copay at the time of your appointment. If you are unable to pay, you will be required to reschedule your appointment.

REGARDING PATIENTS WITH NO INSURANCE:
Payment is due at the time of service.

REGARDING PATIENTS WITH MEDICARE:
We will file all charges with Medicare and your supplemental insurance if applicable. If you do not have supplemental insurance, you will be billed for the 20% not paid by Medicare, or any deductible that has not been met.
MEDICAID DOES NOT COVER PODIATRY SERVICES FOR INDIVIDUALS OVER THE AGE OF 18.

REGARDING WORKMEN'S COMPENSATION/AUTO/LIABILITY:
Our office requires authorization prior to the initial visit. If authorization has not been received by the time of your visit, our office will attempt to obtain it. If we do not receive authorization, then your personal health insurance information will be taken for filing purposes. You will be responsible for all fees until the case has been settled.
WE DO NOT BILL ATTORNEYS IN WORKCOMP, AUTO, AND/OR LIABILITY CASES.

MINOR PATIENTS:
Patients under the age of 18 must have a parent and/or guardian accompany them to our office before treatment can be rendered. Arrangements must be made prior to being seen with the parent and/or guardian for any copays and payments to be made at the time of treatment.

LAB:
Our office uses an outside laboratory service. In the event that a lab test is performed, you will receive a separate bill for the lab services.

CUSTOM ORTHOTICS:
If your insurance does not cover orthotics or your deductible has not been met, a payment of half the price of the orthotics will be expected prior to ordering. The remaining half is due at the time your orthotics are dispensed.

It is always your responsibility to be sure that your account is settled, regardless of insurance or any other circumstances (such as litigation). The Patient is responsible for costs associated with collecting owed balances including but not limited to, collection agency fees, attorney fees, and court costs.

I hereby authorize the release of any information necessary to file a claim with my insurance company and assign benefits to Central Kansas Podiatry Associates.

I acknowledge that I have read the billing policies listed above, agree, and understand my responsibilities as a patient at Central Kansas Podiatry. I also understand that if I fail to pay charges, I imply discontinuation of podiatry services.

_____ _____ _____

Signature Date Chart number

We require that you call at least 24 hours in advance. Appointments that are missed will accrue a fee of $25.00 that will be charged to the patient's account. Thank you in advance for your cooperation.

2081 N Webb Road
Wichita, KS 67206
Phone: 316-269-3338
Fax: 316-264-5516

CKPA Pain Analysis Survey

Name: _____ Date: _____ Age: _____

Please check any of the following conditions you are currently experiencing or suffering from:

- ☐ Flat Feet _____
- ☐ Poor coordination _____
- ☐ Heel or Arch Pain _____
- ☐ Leg pain (shin splints) _____
- ☐ Achilles tendon pain _____
- ☐ Neck Pain ____
- ☐ Ankle swelling or stiffness _____
- ☐ Absent or decreased Pedal pulses _____
- ☐ Foot/Toes/Legs Burn _____
- ☐ Back Pain _____
- ☐ Pain in feet or heels when getting out of bed _____
- ☐ "Toe-in" or "Toe-out" gait (walking) _____
- ☐ Pain or fatigue of feet or legs in activity or exercise _____
- ☐ Ankle instability (easy twisting injuries) _____
- ☐ Difficulty/Pain with brisk walking or running occurring with same distance____
  - ☐ This pain in legs is relieved by rest _____
- ☐ Coldness in the legs or feet that is uncomfortable _____
- ☐ Non / Poor healing sore, ulcer or gangrene on the leg or foot _____
- ☐ Feet/Toes feel numb _____
- ☐ Pale or blue discoloration of the feet _____

Please answer the following about the above conditions:

Do the above conditions disrupt your lifestyle and activities of daily living? Yes / No

Is this condition causing or are you suffering with any of the following:

Tingling/Numbness in:	**Pain radiating into:**	**Weakness of the:**	**Difficulty with:**
☐ Legs R / L	☐ Ankle R / L	☐ Legs R / L	☐ Standing
☐ Ankle R / L	☐ Feet R / L	☐ Ankle R / L	☐ Walking
☐ Feet R / L	☐ Toes R / L	☐ Foot R / L	☐ Sitting
			☐ Bending
			☐ Lifting
			☐ Kneeling

How long have you been suffering with this condition? Days / Weeks / Months / Longer

Is this condition affecting your ability to perform daily tasks? Yes / No

Would you like to get rid of or reduce this problem? ☐ Yes ☐ No

There may be treatment options or solutions for the pain you are experiencing. Please let us know what you would like to do today.

☐ I would like to discuss the above conditions with the Doctor so I can make an educated decision about my health.

☐ If it were available, I would be interested in receiving treatment for this condition in this office.

☐ If available, I would be open to have a medical test to further evaluate my problem.

☐ I would prefer to be treated at another doctor's office.

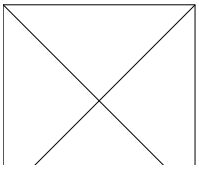
☐ I am not interested in handling this condition at this time.

☐ I am having no foot problems at this time and does not pertain to me.

_____ _____ _____

Patient Signature Chart Number Physician Signature

Do I Need a Test for CVI?



Chronic Venous Insufficiency (CVI) is a serious circulatory problem in which the leg veins cannot pump enough blood back to your heart. It affects over 2.5 million Americans, most over the age of 40. Symptoms of CVI include varicose veins, skin problems, leg and ankle swelling, tight calves, and legs that feel heavy, tired, restless, or achy. Factors that can increase the risk of CVI include pregnancy, obesity, and smoking, standing or sitting for long periods of time and not getting enough exercise. Answers to these questions will determine if you are at risk for CVI and if a vascular exam will help us better assess your vascular health status.

Name: _____ Chart#_____ Date: _____

Circle "Yes" or "No":

1.	Are your legs swollen, painful, red or warm to the touch? *(451.0)*	Yes	No _____
2.	Have you had a blood clot in a vein that caused inflammation, pain or irritation? *(451.2)*	Yes	No _____
3.	Do you have varicose veins (veins that are enlarged or swollen and raised above the surface of the skin) in the legs? *(454.0-454.9)*	Yes	No _____
4.	Have you had a Deep Vein Thrombosis (DVT) in the past and are experiencing pain, swelling, changes in skin color, cellulites, or non-healing ulcers? *(459.10-459.19)*	Yes	No _____
5.	Do your legs feel heavy, tired, restless or achy? *(459.31-459.39)*	Yes	No _____
6.	If you push on your swollen foot, ankle or leg for 10 seconds and release, does your fingerprint leave a dimple? *(459.81)*	Yes	No _____
7.	If your feet, ankles and legs are swollen, does the skin look stretched or shiny? *(459.81)*	Yes	No _____
8.	Do you have an ulcer on the inside of your ankle? *(707.10-707.19)*	Yes	No _____

Patient Signature: _____ Doctor _____