Dr. Thomas F. Bembynista
Diplomate, American Board Podiatric Surgery
Fellow, American College of Foot & Ankle Surgeons

Patient Information:

Date _____ Social Security Number _____ Birthdate _____

Last Name _____ First Name _____ Middle Initial _____

Address _____

City _____ State _____ Zip _____

Home Phone(____) _____ Cell Phone (____) _____ E-Mail _____

Sex: ❑ Male ❑ Female Marital Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Employer _____ Business Phone (____) _____ Extension _____

Occupation _____

Whom may we thank for referring you? _____ _____
First Name Last Name

In case of emergency, who should we contact? _____ Phone(____) _____

Insurance Information:

PRIMARY Insurance Company _____ Subscriber I.D. # _____

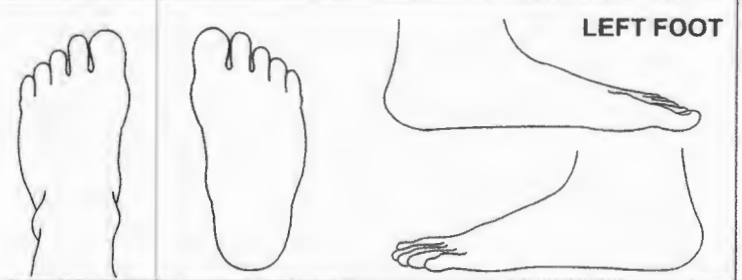
SECONDARY Insurance Company _____ Subscriber I.D. # _____

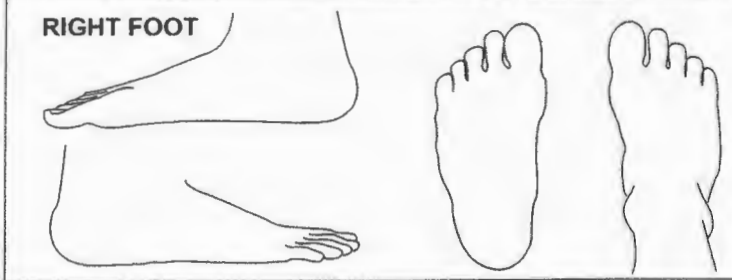
Assignment & Release:

Insurance Authorization & Assignment: I hereby authorize to furnish information to insurance carriers concerning my illness and treatments and to my referring physicians if so requested. I hereby assign to the physician all payments for medical services rendered to myself or to my dependents I understand that I am responsible for any amount not covered by insurance. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____
(Parent of Guardian if Minor)

Tell Me Where It Hurts:





Please mark the location of your first problem or pain on the diagram above
Describe your problem below and its cause if you know it. Please describe associated pain to the right →

Briefly describe your problem:

_____

_____

_____

_____

_____ Is this problem work related? ❑ Y ❑ N

Date of injury: _____ Date reported to employer: _____

PAIN: Please indicate the severity of your pain or discomfort:
0 = No Pain • **1** = Light • **2** = Moderate • **3** = Strong • **4** = Severe

My Pain/Discomfort is:
- ❑ Shooting Pain _____
- ❑ Throbbing Pain _____
- ❑ Sharp Pain _____
- ❑ Burning Pain _____
- ❑ Itching _____
- ❑ Aching Pain _____
- ❑ Tenderness _____
- ❑ Dull Pain _____
- ❑ Tingling _____
- ❑ Numbness _____

How long ago did the problem (pain) start?
❑ Days ❑ Weeks ❑ Months ❑ Years Ago

The pain from my problem occurs:
❑ While Walking and/or ❑ While Not Walking
❑ and/or: _____

Previous medical treatments(s) or home remedies:

_____

_____

Patient's Doctors - Please tell us whom to thank and with whom to coordinate your care

Family/ Primary _____ _____ ❑ Y ❑ N ❑ 2nd Opinion ❑ Surg. Eval. ❑ Consult

Specialist _____ _____ ❑ Y ❑ N ❑ 2nd Opinion ❑ Surg. Eval. ❑ Consult

Other Podiatrist _____ _____ ❑ Y ❑ N ❑ 2nd Opinion ❑ Surg. Eval. ❑ Consult

Medical History:

Shoe Size:	Weight:	Height:

1) Have you had/been treated for:

❑ Corns/Calluses	❑ Warts	❑ Athlete's Foot
❑ Leg or Foot Ulcers	❑ Fungal Nails	❑ Ingrown Nails
❑ Broken Foot Bone(s)	❑ Neuroma	❑ Foot Numbness
❑ Hammer/Mallet Toes	❑ Broken Ankle	❑ Ankle Sprain
❑ Cramps in legs/feet	❑ Bunions	❑ Flat Feet
❑ Lower Back Pain	❑ Arch Pain	❑ High Arch Feet
❑ Gait (walking) Problems	❑ Knee Pain	❑ Heel Pain
❑ Childhood Foot problems	❑ In-toeing	❑ Toe walking
	❑ Rash	❑ ***NONE of These***

2) Did you previously/do you now wear:

Shoe /nserts? ❑ Y ❑ N — Still Use Them? ❑ Y ❑ N — Do or did they help? ❑ Y ❑ N

Orthotics? ❑ Y ❑ N — Still Using Them? ❑ Y ❑ N — Do or did they help? ❑ Y ❑ N

2B) The orthotics were obtained from: ❑ Another Podiatrist ❑ An Orthopedist ❑ A Physical Therapist ❑ A Chiropractor ❑ Other:_____

3) Are your first steps out of bed painful? ❑ Y ❑ N... then subsides? ❑ Y ❑ N

4) Do you get leg cramps during the day? ❑ Y ❑ N... at night? ❑ Y ❑ N

5) What percent of your waking hours do you spend on your feet?
❑ 20% ❑ 40% ❑ 60% ❑ 80% ❑ 100%

6) List the sports/types of dance you are active in:

_____

7) Does foot pain limit your desired activities? ❑ Y ❑ N

8) Do you have any difficulty in walking? ❑ Y ❑ N

9) Any pain in calves or buttocks when walking? ❑ Y ❑ N

10) Is the pain relieved by stopping or standing still? ❑ Y ❑ N

Family History:

1) List the relationship to you of family members who have had:

Diabetes _____ Foot Problems _____

Arthritis _____ Heart Attack _____

Stroke _____ High Blood Pressure _____

Cancer _____ Birth Defects _____

Medications/Alcohol/Smoke

1) Do you smoke now? ❑ Y ❑ N Packs/day _____ Years _____

2) Did you ever smoke? ❑ Y ❑ N Packs/day _____ Years _____

3) If you quit, when did you do so?_____

4) Alcoholic beverages? (*check one*)
❑ None ❑ Rarely ❑ Moderately ❑ Daily ❑ Quit

5) Recreational drugs? (*check one*)
❑ None ❑ Rarely ❑ Moderately ❑ Daily ❑ Quit

6) Are you currently taking any medications? (*list below*) ❑ Y ❑ N

7) If you are diabetic, date last seen by your primary physician?

_____

8) List your medications below, with dosage, frequency, and for treatment of:

_____

_____

_____

_____

_____

_____

9) Are you taking your medications as prescribed? ❑ Y ❑ N

11) Do you have or have you been treated for:

❑ Stroke	❑ Heart Attack	❑ High Blood Pressure
❑ Phlebitis	❑ Vascular Disease	❑ A Heart Condition
❑ Diabetes	❑ Poor Circulation	❑ Headache
❑ Hepatitis	❑ Liver Disease	❑ Anemia
❑ Gout	❑ Arthritis	❑ Osteoporosis
❑ Sciatica	❑ Rheumatic Fever	❑ Lyme's Disease
❑ Alzheimer's	❑ Keloid/Thick Scar	❑ Hearing/Ear Disorder
❑ Epilepsy	❑ Nerve Disorder	❑ Psychiatric Disorder
❑ Glaucoma	❑ Kidney Disease	❑ Thyroid Problem
❑ Asthma	❑ Lung Disease	❑ Tuberculosis
❑ Cancer	❑ Stomach Ulcer	❑ ***NONE of These***

❑ Other(s): _____

12) Do you have vascular grafts? *(if yes, explain below)* ❑ Y ❑ N

13) Do you have joint implants? *(if yes, explain below)* ❑ Y ❑ N

14) Do you have replacement heart valves? ❑ Y ❑ N

15) Are you now under active chemotherapy? ❑ Y ❑ N

16) Have you had any serious illness? *(list under other concerns)* ❑ Y ❑ N

17) Have you had any surgery? *(if yes, explain below)* ❑ Y ❑ N

18) Have you ever been hospitalized or under medical care over 24 hours? *(if yes, explain below)* ❑ Y ❑ N

19) Are you slow to heal after cuts? ❑ Y ❑ N

20) Any abnormal bruising, bleeding, or scaring? ❑ Y ❑ N

21) No. of childbirths: ____ Are your currently pregnant? ❑ Y ❑ N

Had Surgery For:	On The Date Of:	With Complications Of:

Allergies:

Is there a history of skin reaction or other outward reaction or sickness following an injection, oral, or topical administration of:

	Yes	No	If yes, what happens
1) Penicillin	❑	❑	
2) Other antibiotics (*list below*)	❑	❑	
3) Morphine	❑	❑	
4) Codeine	❑	❑	
5) Demerol	❑	❑	
6) Other narcotics (*list below*)	❑	❑	
7) Aspirin	❑	❑	
8) Empirin, Tylenol (*circle*)	❑	❑	
9) Advil, Aleve, Motrin (*circle*)	❑	❑	
10) Other pain remedies (*list below*)	❑	❑	
11) Sulfa drugs?	❑	❑	
12) Adhesive tape?	❑	❑	
13) Shrimp, Iodine, Merthiolate	❑	❑	
14) Any other drugs/medications	❑	❑	

15) Others: _____

_____

Other Concerns:

1) Is there anything else you want to tell the Doctor? ❑ Y ❑ N

2) Illnesses/Explanations:_____

_____

_____

_____

_____

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Financial Policy :I authorize release of any information necessary to process claims. I request payment to Dr. Bembynista and or Regional Foot Centers ,I understand that I am financially responsible for charges not covered by my insurance.

If your plan has a copayment ,deductible and/or co-insurance you will be expected to pay your portion prior to receiving any service.

Payment is due at the time of service.Any account balance is expected to be paid in full when 30 days. Past due accounts, more than **90 days**, will be turned over to our collection agency and a **35% fee** of the balance due will be added to cover collection costs.

Patient/Responsible Party Signature_____Date_____

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. (Assignment of Benefits): I authorize payment of medical benefits to the practice named above. (Release of Information): I authorize the release of any medical information necessary to process this claim. (HIPAA Privacy): I acknowledge that I received my HIPAA Privacy Practices Notice. (Medication History): I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____Date:_____

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Fax: 816.461.0393

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Kansas City, MO 64154
Tel.: 816.455.3636