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 ❑ Separatec

Employer _____ Business Phone (___) _____ Extensio _____

Occupation _____

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

In case of emer ency, who should we contact? Phone

Insurance Information

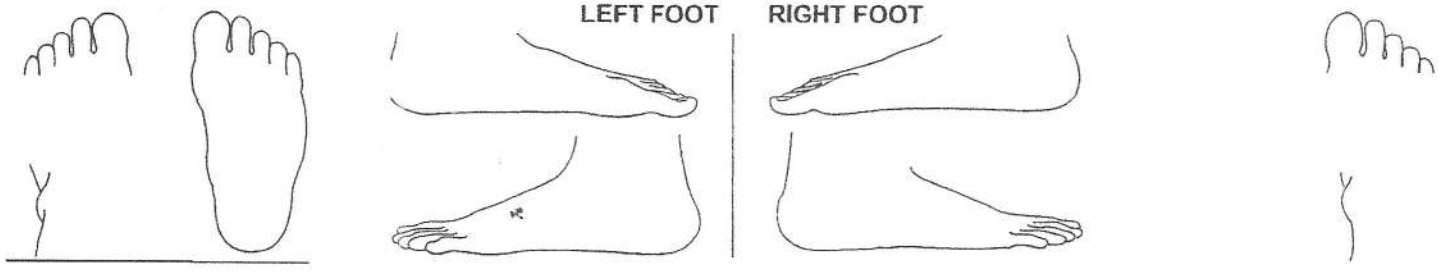
PRIMARY Insurance Company _____ Subscriber I.D. # _____

SECONDARY Insurance Company _____ Subscriber I.D. # _____

Insurance Authorization & Assignment: I hereby authorize *Regional Foot Center* 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 dependent 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:

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

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 Inserts? ❑ 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

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 _____

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:

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: _____

_____

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

2) Illnesses/Explanations: _____

_____

_____

_____

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NOTICE OF PRIVACY PRACTICES:

I acknowledge that I was provided with a copy of the Notice of Privacy Practices, and that I have read (or had the opportunity to read it if I so chose). I also acknowledge my understanding of the notice.

CONSENT OF TREATMENT:

I consent to such diagnostic procedures and medical care as deemed necessary, by the Doctor, for my treatment. I also consent to the taking of photographs, which will be used for medical education purposes.

FINANCIAL RESPONSIBILITY:

I understand when discussing any treatment recommended by Dr. Thomas Bembynista, I am responsible for all charges. I acknowledge that my insurance may not cover certain charges for reasons including but not limited to the following:

1) Not bringing or not getting a referral
2) Pre-certification is not obtained
3) Services are not covered
4) Insurance is not in effect

Initial_____

I understand that there is a $40 charge for any returned check. Account balances are due within 30 days unless payment arrangements are set up with our office. Outstanding account balances are turned over to a collection agency at 60 days. A 40% fee will be added to the outstanding balance to cover collection costs. Initial_____

Our office will file with your insurance company within business 5 days of your visit. I acknowledge that I am solely responsible for any charges my insurance company does not cover. I understand my insurance company may have co-pays, deductibles, and co-insurances. Initial_____

New patients are required to pay for services on the first visit. This includes co-pays, deductibles, and co-insurances. These fees will be reviewed with you and are generally $200 or less. It is important that you understand what your insurance policy covers. Co-pays apply to the visit only. It does not cover services such as x-rays or other treatments which go towards your deductible and need to be paid at the time of service. Initial_____

I have read, understand, and agree to all of the above

Name of Patient (Please Print)_____

Signature of Financially Responsible Party _____Date_____

Name of Financially Responsible Party (Please Print)_____Date_____

Overland Park

8695 College Blvd. #220

Overland Park, KS 66210

Tel:913-894-0660

Green Hills

8530 N. Green Hills Rd.

Kansas City, MO 64154

Tel:816-455-3636

Fax:816-461-0393

Dr. Thomas F. Bembynista
Diplomate, American Board Podiatric Surgery

Acct # _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize DR. BEMBYNISTA to use or disclose my Personal Health Information (PHI) as described below. I understand that, if the organization authorized to receive my PHI is not a health plan or health care provider, the released PHI may no longer be protected by federal privacy regulation. Our Notice of Privacy Practices provides detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practice. It is available upon request.

Patient authorizes communication with family/friends regarding your **care and test results.**

Name _____ Phone # _____ Relation_____

Name _____ Phone# _____ Relation_____

Patient authorizes communication with family/friends regarding your **account and billing.**

Name _____ Phone # _____ Relation_____

Patient authorizes communication with a primary care physician or other physician (first and last name):

1. _____ M.D.
2 _____ M.D.

Best way to contact you regarding messages, responses, appointment reminders etc. (number 1- 5, 1 being the best)

Home phone__ Work phone__ Cell phone__ E-mail Text

May we leave a message on home voicemail?	Yes	No	N/A
May we leave a message with whomever answers the home phone?	Yes	No	N/A
May we call your work and leave a message with the person who answers the phone?	Yes	No	N/A
May we leave a message on work voicemail?	Yes	No	N/A
May we contact you via Email? Email Address:_____			
May we contact you via text message? _____	Yes	No	N/A
May we send out your PHI to a third party system?	Yes	No	N/A

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your PHI in reliance on your consent.

May we fax and/or email to other providers if necessary to medical care	Yes	No	N/A

Signature of patient (or patient's representative)_____ Date _____

Printed legal name of patient (or patient's representative) _____

Overland Park Office
8695 College Blvd #220
913-894-0660

Green Hills Office
8530 N. Green Hills Rd.
816-455-3636

Fax# 816-461-0393
Email: yvonne@kcfootcare.com