

Kim Foot and Ankle Centers

PLEASE PRINT

PATIENT INFORMATION

Last Name _____		First Name _____		MI _____	DOB ____/____/____		AGE ____
ADDRESS _____			APT _____	CITY _____		STATE _____	ZIP _____
HOME PHONE # _____		CELL PHONE # _____		WORK PHONE # _____			
***** CIRCLE WHICH NUMBER YOU PREFER TO USE FOR REMINDER CALLS *****							
SEX M F	MARITAL STATUS _____		DRIVER'S LICENSE # _____		SOCIAL SECURITY # ____-____-____		
EMPLOYER NAME/ADDRESS _____				OCCUPATION _____			
EMERGENCY CONTACT _____			PHONE # _____		RELATIONSHIP TO PATIENT _____		
EMAIL _____			PREFERRED LANGUAGE		ENGLISH	SPANISH	OTHER
RACE		<input type="checkbox"/> NATIVE AMERICAN	<input type="checkbox"/> AFRICAN AMERICAN	<input type="checkbox"/> ASIAN	<input type="checkbox"/> WHITE	<input type="checkbox"/> HISPANIC	<input type="checkbox"/> OTHER
PHARMACY _____		PHONE # _____					

COMPLETE THIS SECTION ONLY IF THE PATIENT IS A MINOR

RESPONSIBLE PARTY NAME _____			RELATIONSHIP TO PATIENT _____				
ADDRESS _____			CITY _____		STATE _____		ZIP _____
HOME PHONE # _____		CELL PHONE # _____		WORK PHONE # _____			

REFERRAL SOURCE

<input type="checkbox"/> FAMILY/FRIEND	<input type="checkbox"/> INSURANCE PROVIDER LIST	<input type="checkbox"/> INTERNET SEARCH	<input type="checkbox"/> PHYSICIAN	<input type="checkbox"/> OTHER
DOCTOR _____		PHONE # _____		
HOME PHONE # _____		CELL PHONE # _____		WORK PHONE # _____

MEDICAL INFORMATION

PRIMARY CARE PHYSICIAN _____		PHONE # _____	DATE LAST SEEN ____/____/____	
ADDRESS _____		CITY _____		STATE _____ ZIP _____

LIST ANY SURGERIES AND/OR HOSPITALIZATIONS

PROCEDURE	DATE
_____	_____
_____	_____
_____	_____

LIST ALL MEDICATIONS (BOTH PRESCRIBED AND OVER THE COUNTER) AND SUPPLEMENTS

MEDICATION	FREQUENCY	MEDICATION	FREQUENCY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PATIENT NAME _____ DOB ____/____/____

ALLERGIES – PLEASE LIST

ANTIBIOTICS: PENICILLIN SULFA KEFLEX
PAIN MEDS: CODEINE MORPHINE ASPIRIN NSAIDs
OTHER: SHELLFISH IODINE ADHESIVE TAPE GENERAL/LOCAL ANESTHETIC

REVIEW OF SYSTEMS – PLEASE CIRCLE ALL THAT APPLY

CONSTITUTIONAL SYMPTOMS: CHILLS DIZZINESS FEVER FATIGUE
EENT: BLURRED VISION / CHANGE IN VISION / CHANGE IN HEARING / RINGING IN EARS / DIFFICULTY WITH SWALLOWING / SINUS PROBLEMS OR INFECTIONS / SORE THROAT / COUGH
GASTROINTESTINAL: CONSTIPATION / DIARRHEA / GERD / NAUSEA / REFLUX / HEPATITIS / CIRRHOSIS / PANCREATITIS
GENITOURINARY: RENAL (KIDNEY) DISEASE / FREQUENT URINATION / STD / PROSTATE DISEASE
SKIN DISORDERS: RASH / ITCHING / CHANGE IN SKIN COLOR / CHANGE IN HAIR / HIVES / PSORIASIS / NON-HEALING WOUNDS / EASY SCARRING
HEMATOLOGIC/LYMPHATIC: POOR CIRCULATION / PVD / LEG OR CALF PAIN / REST PAIN / VEIN PROBLEMS / SWELLING / VARICOSE VEINS / PHLEBITIS / LEG ULCERS / BLOOD CLOTS / DVT / PAST TRANSFUSIONS / LEUKEMIA / LYMPHOMA / HIV/AIDS / SICKLE CELL / CANCER / RADIATION TREATMENT
CARDIOVASCULAR: CHEST PAIN / HEART ATTACK / SHORTNESS OF BREATH / SWELLING OF FEET AND/OR ANKLES / HIGH/LOW BLOOD PRESSURE / MITRAL VALVE PROLAPS / PACEMAKER
ENDOCRINE: DIABETES / IF DIABETIC, HOW LONG _____ WHAT TYPE _____ CONTROLLED **YES / NO** / THYROID DISEASE / HORMONAL PROBLEMS / EXCESSIVE THIRST OR URINATION
NEUROLOGICAL: BURNING / TINGLING / NUMBNESS / PARALYSIS / TREMORS / STROKE / HEAD INJURY / MULTIPLE SCLEROSIS / CEREBRAL PALSY
RESPIRATORY: ASTHMA / BREATHING DIFFICULTY / COPD / LUNG DISEASE / TUBERCULOSIS / SLEEP APNEA
MUSCULOSKELETAL: JOINT PAIN / MUSCLE TENDERNESS / MORNING STIFFNESS / WEAKNESS / DIFFICULTY WALKING / RHEUMATOID ARTHRITIS / OSTEOARTHRITIS / JOINT REPLACEMENT / FIBROMYALGIA / OSTEOPOROSIS / GOUT
PSYCHOLOGICAL: ANXIETY / DEPRESSION / MEMORY LOSS / CONFUSION / SUICIDAL THOUGHTS / CHEMICAL DEPENDENCY

SOCIAL AND FAMILY HISTORY

USE OF ALCOHOL: NEVER NO LONGER USE HISTORY OF ALCOHOL ABUSE
FREQUENCY: _____ # OF DRINKS PER MONTH / WEEK / DAY
USE OF TOBACCO: NEVER NO LONGER USE CURRENT USER
FREQUENCY: _____ # OF CIGARETTES PER MONTH / WEEK / DAY
USE OF RECREATIONAL DRUGS: NEVER NO LONGER USE CURRENT USER
FREQUENCY: _____ # OF TIMES PER MONTH / WEEK / DAY
DO YOU HAVE A FAMILY HISTORY OF: DIABETES – M / F CANCER – M / F HEART DISEASE – M / F HIGH BLOOD PRESSURE – M / F STROKE – M / F CORONARY ARTERY DISEASE – M / F THYROID – M / F RHEUMATOID ARTHRITIS – M / F
 OTHER _____ - M / F
PLEASE CIRCLE WHETHER IT IS ON YOUR MOTHER'S (M) OR FATHER'S (F) SIDE FOR FAMILY HISTORY.

ARE YOU PREGNANT? YES OR NO
ARE YOU NURSING? YES OR NO
ARE YOU TAKING BIRTH CONTROL PILLS? YES OR NO

PATIENT HEIGHT: _____

WEIGHT: _____

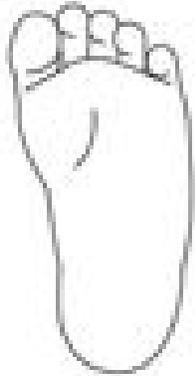
SHOE SIZE: _____

CURRENT PROBLEM(S): IF YOU HAVE MORE THAN ONE PROBLEM – PLEASE REQUEST ADDITIONAL SHEET(S)

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW USING 'X's.'

LEFT FOOT

RIGHT FOOT

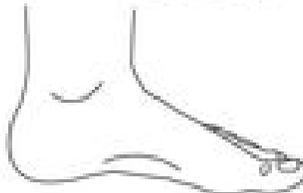


BOTTOM OF FOOT

TOP OF FOOT

BOTTOM OF FOOT

TOP OF FOOT



INSIDE OF FOOT

OUTSIDE OF FOOT

OUTSIDE OF FOOT

INSIDE OF FOOT

PROBLEM(S): _____

WAS THIS PROBLEM CAUSED BY AN INJURY? YES NO

(DESCRIBE) _____

IF YES, WAS IT WORK-RELATED INJURY? YES NO

HOW LONG AGO DID THIS PROBLEM START? _____ **DAYS / WEEKS / MONTHS / YEARS**

DID YOUR PAIN OR PROBLEM BEGIN: BEGIN ALL OF A SUDDEN GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? NO PAIN SHARP DULL ACHING BURNING RADIATING
 ITCHING STABBING OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE OF 0 TO 10? (PLEASE CIRCLE)

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORSE)

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? WALKING STANDING DAILY ACTIVITIES RESTING
 DRESS SHOES HIGH HEELS WORSE AT NIGHT OR SLEEPING ANY CLOSED TOE SHOE RUNNING NO PAIN

OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTERS? _____

REFERRAL POLICY

If your insurance is part of a Managed Care plan (*HMO, POS, EPO, etc.*), failure to obtain a valid referral from your pharmacy care physician (*PCP*) may result in reduced or no benefits being paid.

NON-COVERED FOOT CARE

Your insurance carrier may determine that your foot care is an excluded service, in which case no reimbursement will be made. Should this occur, the responsibility of payment will remain yours as the recipient of these services (*This includes orthotics, splints, over the counter medications, heel cups, pads, and toe separators, i.e anything that is given to you in this office that your carrier may not pay*).

CONSENT TO TREAT AND FINANCIAL RESPONSIBILITY

I hereby authorize Dr. Ray Kim, FACFAS to render medical services and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in case of emergency.

Patient Name (*Please Print*) _____

Signature of Patient, Parent, or Legal Guardian _____ **Date** ___/___/___

Payment is expected at the time of your visit. We accept cash, check, or credit cards. As our patient you are responsible for all payments for any deductible, co-insurance, co-pay, or non-covered services. Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you. As our patient you are responsible for any unpaid bills 60 days after insurance is filed. If for any reason the account becomes delinquent, I agree to pay for all collection and legal fees. I authorize Dr. Ray Kim, FACFAS to release medical information pertinent to filing of an insurance claim for me. There is a service fee of \$25 for all returned checks.

Patient Name (*Please Print*) _____

Signature of Patient, Parent, or Legal Guardian _____ **Date** ___/___/___

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

We are required by law to provide you with a copy of your Notice of Privacy Practices. To ensure that our records are accurate, please sign this form to acknowledge that you have been provided with a copy of your notice.

To the best of my knowledge, I have answered the questions on this form accurately. 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.

Patient Name (*Please Print*) _____

Signature of Patient, Parent, or Legal Guardian _____ **Date** ___/___/___