JAYHAWK
FOOT & ANKLE CLINIC

9300 MEADOW VIEW DR., STE. 101
LENEXA, KS 66227
PHONE: 913-871-2183
FAX: 913-780-4834

PODIATRIC HISTORY & PHYSICAL & REVIEW of SYSTEMS (ROS)

Patient Name: _____ SS#_____DATE _____
DOB _____ AGE: _____Home Phone_____
Cell Phone _____Email _____
Address, City, State, Zip_____
Employer name _____ Employer phone _____
Primary Ins_____ Subscriber _____DOB _____
ID# _____Group_____Copay $_____
Second Ins_____Subscriber_____DOB _____
ID# _____ Group_____
Physician_____Ph#_____
Pharmacy _____ Ph#_____
Recommended by or Referred by: _____
HT_____WT ____ Shoe Size____

************STOP! DO NOT FILL IN BELOW THIS LINE ON THIS PAGE***********

1) CC: CHIEF COMPLAINT:
- A) Location of problem_____
- B) Duration of problem_____
- C) Severity of problem_____
- D) Changes in problem_____
- E) Past treatment for problem_____

2) PAST MEDICAL HISTORY:
- A) Current medications_____
- B) Allergies_____
- C) Hospitalizations_____
- D) Past surgeries_____
- E) Diabetes___ High BP ___ Heart Dz ___ Resp Dz___ PVD___ Arthritis___ Liver Dz __ Kidney Dz__
- F) Past medical problems_____

3) SOCIAL HISTORY: A. Smoke _____ Alcohol _____ Drugs _____

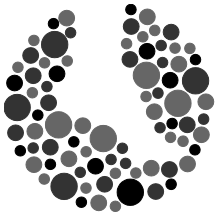
4) REVIEW OF SYSTEMS:

HEAD _____EYES_____
EARS _____NOSE _____
THROAT _____ HEART _____
LUNGS _____ ABDOMEN _____

5) PODIATRIC PHYSICAL EXAM:
- A) General _____
- B) Vascular_____
- C) Neurological_____
- D) Dermatological_____
- E) Musculoskeletal_____
- F) Biomechanical_____

6) DIAGNOSIS (ASSESSMENT)_____ ICD_____
_____ ICD_____
_____ ICD_____

7) TREATMENT (PLAN)
- A) _____ CPT_____
- B) _____ CPT_____
- C) _____ CPT _____



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ONLINE ACCESS TO PERSONAL HEALTH RECORDS

We are going digital! Enroll with us for free online access to your Personal Health Records, where you can view your current and past medical history and prescriptions. It is simple, safe, and private.

☐ YES! I would like to enroll.

Patient (or legal guardian's) **EMAIL** address:

_____

Once you turn in your e-mail address to our office staff, we will provide you with a temporary PIN Number, which you may then use to access your Personal Health Records online.

☐ No, I prefer not to access my medical information online at this time.

PATIENT FINANCIAL OBLIGATION

Patient Name **(PRINT):** _____
I understand that I am financially responsible for any and all services rendered by physicians and staff at Jayhawk Foot & Ankle Clinic. I also understand that in event that my insurance carrier does not make full payment of all charges within 60 (sixty) days after services are rendered, I am totally responsible for any and all balances thereof.

_____ _____
Signature Date

CONTACT INFORMATION

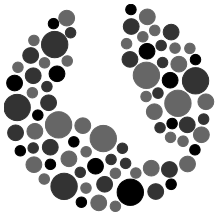
Emergency contact name and phone_____

Circle Preferred method of contact: CELL HOME WORK EMAIL

Circle Race: American Indian or Alaskan Native Asian Black or African American
Hispanic or Latino Native Hawaiian or Other Pacific Islander White

Language _____

LENEXA LIBERTY LEAWOOD PAOLA



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INSURANCE INFORMATION

Ins. Subscriber Name _____ Subscriber Birthdate _____
Subscriber Social Sec. # _____
Employer of Subscriber _____

IF SECONDARY INSURANCE: INS. Subscriber Name _____
Sec. Ins. Subscriber Birthdate _____ Social Sec. # _____
Sec. Ins. Employer Name _____ Sec. Ins. Work Phone _____

PODIATRY INFORMATION

Is this work related? (Y/N) _____ Describe your foot problem _____
_____.
How long has this been bothering you? _____
Any past problems with your feet or ankles? _____

Are you **ALLERGIC** or sensitive to any of the following and, if so, describe your reaction:
Antibiotics (Penicillin, Sulfa, etc.)? _____ Reaction _____
Any Medicines? _____ Reaction _____
Tape? _____ Betadine (Iodine) _____ Other _____

Have you had problems taking Aspirin or Ibuprofen (Advil, Motrin)? (Y/N) _____ Reaction _____
Have you had problems with local anesthetics (Novocain, Lidocaine, Marcaine)? (Y/N) _____
Reaction _____

GENERAL HEALTH

Do you have **Diabetes**? (Y/N) _____ If yes, what Diabetic medicine do you take (include dosage)?
_____Number of years: _____
Have you had any serious illnesses, if yes, please explain_____
Have you had any major surgeries, if yes, please explain_____
Have you had any hospitalizations, if yes, please explain _____
Are you under a physician's care (Y/N)? _____ If yes, for what condition? _____
Date you last saw your doctor? _____ May we contact your doctor about your health? _____
If no, explain why _____
Is there a chance you may be pregnant? Yes No N/A

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*****MEDICATIONS (WE ARE NOT AFFILIATED WITH OLATHE MED TO GAIN ACCESS TO YOUR MEDICATIONS SO PLEASE FILL OUT OR ATTACH MEDICATION LIST THANK YOU)*****

What medications are you taking regularly? (please include dosages):

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

9._____

10._____

I hereby give permission to **PHYSICIANS AND STAFF AT THIS CLINIC** examine and treat my feet and related conditions medically, surgically or orthopedically and acknowledge that I am responsible for all financial obligations incurred for services rendered.

_____ _____
Signature Date

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HIPAA AUTHORIZATION FORM

Jayhawk Foot and Ankle clinics protect our patient's personal medical information to the upmost level. To share any of this information with anyone other than yourself we require your permission. At times this information is needed by other entities to provide appropriate medical care. This form is to help us be prepared to handle a request for your medical information in a way that you would prefer.

Patient's Full Name	**Patient's last four of Social Security Number/Medical Record Number**
Address	**Patient's Date of Birth**
City, State Zip Code	**Patient's Telephone Number**

By initialing I consent Jayhawk Foot and Ankle Clinic to provide my medical information to the following parties if requested

1. A. Family members:_____
   B. Other medical professional: _____
   C. Insurance company including disability_____
   D. Employer and/or government agency: _____
   E: Other: _____

UNLESS YOU INITIAL HERE, INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL/MAY BE INCLUDED WITH YOUR MEDICAL RECORDS:
NO, **DO NOT** DISCLOSE THIS INFORMATION * _____

2. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
3. I may revoke this authorization by notifying **JAYHAWK FOOT AND ANKLE CLINIC** in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies.
THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**	**Date of Birth**
Signature of Guardian* or Personal Representative of Patient's Estate	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**

Official Use Only		
Received	**Processed By**	**Log #**

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General Medical Information:
This information is important for our records and your health.

Patient Name: _____Birthdate: _____

Check any of the following you have, or have had a problem with:

( ) Heart	( ) Asthma	( ) Circulation	( ) Hormones
( ) Stomach Ulcers	( ) Gout	( ) Arthritis	( ) Tuberculosis
( ) Skin	( ) Healing	( ) Kidneys	( ) Lungs
( ) Frequent infections	( ) Rheumatic fever	( ) Anemia	( ) High blood pressure
( ) Unexplained weight loss	( ) Bladder	( ) Cancer	( ) Neurological disorder

Do you have any artificial joints:
Hip Yes ____ No___
Knee Yes ____ No___
Other Yes ___ No ___
Do you have heart valve implants or heart artery stents? Yes ___ No ___
If so, which one? _____

Family History:
Mother Living _____Deceased _____Cause of Death _____
Father Living _____Deceased _____Cause of Death _____
Brother Living _____Deceased _____Cause of Death _____
Sister Living _____Deceased _____Cause of Death_____

Is there a family (blood relative) history:

( ) Heart Disease	( ) Arthritis	( ) Bleeding Disorder
( ) Neurological disorder	( ) Stroke	( ) Bunions
( ) Flat feet	( ) Diabetes	( ) Hammertoes

( ) Circulation problems in legs or feet

Do you smoke? Yes ___# of packs per day _____ No ____
Did you previously smoke? Yes ___ No ___
Do you drink alcohol or beer? Yes ___ No ____
( ) Light usage: 1-2 per week ( ) Moderate usage: 1-2 per day ( ) Heavy: More than daily
Do you use non-prescription drugs of any kind: Yes ___ No ___ If so, what kind?
_____
Employment: ( ) Sit at job ( ) Stand at job ( ) Stand and walk at job ( ) Retired

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TEXT MESSAGING AND EMAIL MESSAGING CONSENT FORM

Declaration

I consent to the practice contacting me by text message or email for the purpose of appointment reminders. I acknowledge that I cannot physically cancel appointments through the texting and email service. Therefore, I understand I must call the office if I need to cancel or reschedule an appointment. I can cancel this service at any time.

I agree to advise the practice of any mobile number or email changes.

Patient Name (please print) _____

Signature _____

Date of Birth _____

Home Telephone_____

Mobile Telephone _____

Email Address_____

This practice does not share mobile phone contact details or email addresses with any external organization.

____I **DO NOT** CONSENT TO THE PRACTICE CONTACTING ME BY TEXT OR EMAIL