JAYHAWK
FOOT & ANKLE CLINIC

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

Patient Name: _____ SS#_____DATE _____
Preferred Name if any: _____DOB:_____AGE: ____Home Phone_____
Cell Phone _____
Email _____
Address_____
City, State, Zip_____
Primary Care Physician_____Ph#_____
Pharmacy _____ Ph#_____
Recommended by or referred by: _____
HT_____WT ____ Shoe Size____

ALLERGIES

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

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

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

( ) High blood pressure	( ) Liver Disease	( ) Circulation	( ) Hormones
( ) Heart disease	( ) Kidney Disease	( ) Arthritis	( ) Tuberculosis
( ) Respiratory disease	( ) Healing	( ) Gout	( ) Skin
( ) PVD	( ) Rheumatic fever	( ) Anemia	( ) Stomach Ulcers
( ) Neurological disorder	( ) Diabetes	( ) Infections	( ) Cancer

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 Usage: 3 or more daily

Have you had any serious illnesses, if yes, please explain_____
Have you had any major surgeries or hospitalizations, if yes, please explain_____
Are you under a physician's care (Y/N)? _____ If yes, for what condition? _____

*****PRESCRIPTION MEDICATIONS (WE ARE NOT AFFILIATED WITH OLATHE MED OR KU 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): **SEE ATTACHED LIST: _____ NONE: _____**

1._____ 5. _____
2._____ 6. _____
3._____ 7. _____
4._____ 8. _____

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

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

_____	_____	_____	_____
Patient Name (Print)	**Patient or Guardian Signature**	**Date of Birth**	**Date**

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

APPOINTMENT POLICY

It is the policy of the practice to monitor and manage all appointments, no-shows, and late cancellations. Please arrive on time for all of your appointments as it is our goal is to provide excellent care to each patient in a timely manner. If it is necessary to cancel an appointment, patients are asked to call or leave a message at least 24 hours before their appointment time if possible. Notification allows the practice to better utilize appointments for other patients in need of prompt medical care. In the event a patient arrives late as defined by "late arrival" to their appointment, our clinic reserves the right to request a rescheduling of your appointment. **In the event of three (3) documented cancellations or no-shows, we will not reschedule an appointment**. We appreciate your attention to our appointment policy.

LATE ARRIVAL POLICY

Our doctors, medical assistants, and staff aim to make your visit a pleasurable one. In our efforts to make your visit more comfortable and to minimize your waiting time, our office has implemented a late arrival policy. **If a patient is more than 15 minutes late for an appointment, the appointment will need to be rescheduled**. This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day if one is available. We will try to accommodate late-comers as best as possible, but cannot compromise on the quality and timely care provided to our other patients. New patients are encouraged to print off new patient paperwork from the website and fill it out prior to coming in. Otherwise, new patients need to arrive at the office at least 15 minutes prior to the scheduled appointment to complete the paperwork. If a new patient's paperwork is not completed in a timely fashion upon arrival, we may need to accommodate other patients who arrive on time. The doctors and staff at Jayhawk Foot and Ankle Clinic truly appreciate your compliance and understanding with this policy so that we can continue to provide excellent medical care as well as excellent customer service.

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Consent to Receive Text Message Appointment Reminders

By signing below, I authorize Jayhawk Foot & Ankle to contact me by automated SMS text message for appointment reminders, and information I may need to send related to my care. I understand that message/data rates may apply under my cell phone plan.

My text/mobile phone number is:( )

I know that I am under no obligation to authorize Jayhawk Foot & Ankle to send me text messages. I may opt-out of receiving these communications at any time by completing an updated consent form. Please allow 7-10 business days for processing. I understand that text messaging is not a secure format of communication.

By signing below, I indicate I am the primary user for the mobile phone number listed above, I accept the risk explained above and consent to receive text messages via automated technology from Jayhawk Foot & Ankle to the phone number that I have provided.

Patient **Printed** Name:
_____

Signature:
_____

Today's Date: _____ Patient Date of Birth: _____

☐ **TEXT ME PLEASE** ☐ **DO NOT TEXT ME** ☐ **STOP TEXTING ME**

CONSENT TO RECEIVE EMAILED/TEXT BILLING STATEMENTS

☐ **EMAIL** ☐ **DO NOT EMAIL**

☐ **TEXT** ☐ **DO NOT TEXT**

EMAIL INVITE TO PRACTICE FUSION PATIENT PORTAL

YES ____ NO ____

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Patient Name: _____ _____DATE _____
AGE: _____DOB: _____
Primary Care Physician: _____ Referring physician: _____

NAME OF INSURANCE COMPANY: Medicare, Blue Cross, Cigna, Humana, Ambetter, UHC, Aetna
Other:_____

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) Past surgeries_____
D) Diabetes___ High BP ___ Heart Dz ___ Resp Dz___ PVD___ Arthritis___ Liver Dz __ Kidney Dz__
E) Illnesses_____
F) Social History: Smoke _____ Alcohol _____

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

4) DIAGNOSIS (ASSESSMENT) _____
_____
_____

5) TREATMENT (PLAN)
A) _____
B) _____
C) _____