2406 E. RD Mize Road
Independence, MO 64057
816-478-3338: ph
816-373-0054: fax

1161 SE Oldham Parkway
Lee's Summit, MO 64061
816-478-3338: ph
816-373-0054: fax

Heartland Podiatry, PC

PATIENT DEMOGRAPHIC INFORMATION AND FINANCIAL RELEASE

First Name: _____ **MI:** _____ **Last Name:** _____

Preferred Name (If Different): _____ **Date of Birth:** _____ **Age:** ____ **Gender:** M F

Marital Status: *Circle One:* Married Single Divorced Widowed **If Married – Spouse Name:** _____
If Minor, Name of Responsible Party: _____

Address (Street, Apt #): _____

Address (City, State, Zip): _____

Address Type: ☐ Home ☐ Relative ☐ Other

Phone: ☐ (Home) _____ ☐ (Cell) _____ ☐ (Work) _____
<Check Preferred Contact Number Above>

Email Address: _____ **SS#:** _____

Primary Language: _____ **Race:** _____ **Ethnicity:** ☐ Hispanic/Latino OR ☐ Non-Hispanic/Latino

Employed by: _____ **Occupation:** _____

Work Address: _____ **Referred by:** _____

INSURANCE INFORMATION:

Primary Insurance Company: _____ **Policy #:** _____ **Group #:** _____

Subscriber Name: _____ **DOB:** _____ **SS #:** _____

Relationship to Patient: _____ **Employer Name:** _____

Secondary Insurance Company: _____ **Policy #:** _____ **Group #:** _____

Subscriber Name: _____ **DOB:** _____ **SS #:** _____

Relationship to Patient: _____ **Employer Name:** _____

If the Billing address is different than the Patient's Home Address, list information here:
Street Address, City, State, Zip: _____

Emergency Contact Name: _____ **Phone:** _____ **Relationship:** _____

I HAVE RECEIVED AND FILLED OUT THE COMPOUND AUTHORIZATION FORM: RELEASE OF INFORMATION: ☐

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL AND BILLING INFORMATION NECESSARY TO PROCESS PAYMENT FOR CLAIMS AND REQUEST BENEFITS TO BE MAILED DIRECTLY TO THE PHYSICIAN UNTIL I REVOKE SAID AUTHORIZATION IN WRITING. I UNDERSTAND THAT I (AND SPOUSE IF MARRIED, OR PARENT IF MINOR) ASSUME RESPONSIBILITY FOR PAYMENTS OF AMOUNTS DUE FOR SERVICES RENDERED AND ABOVE THE AMOUNT COVERED BY INSURANCE OR THE TOTAL AMOUNT, IF I DO NOT HAVE APPLICABLE INSURANCE COVERAGE. MY SIGNATURE BELOW GUARANTEES MY ASSUMPTION OF RESPONSIBILITY TO THE AMOUNT OWED PURSUANT TO THIS AGREEMENT.

Patient Signature: _____ Date: _____

2406 E. RD Mize Road
Independence, MO 64057
816-478-3338: ph
816-373-0054: fax

1161 SE Oldham Parkway
Lee's Summit, MO 64081
816-478-3338: ph
816-373-0054: fax

Heartland Podiatry, PC
MEDICAL HISTORY

Patient Name: _____ **Date of Birth:** _____

Height: _____ **Weight:** _____ **Shoe Size:** _____ **Blood Pressure (if known)** _____ /_____

Questions	Further Details
Family Physician?	Phone #:
Last Visit to your Physician?	
What Foot Problems brought you to our office today?	
How long has this bothered you?	
Have you injured your foot?	YES NO If yes, How and When?
List any previous foot care/foot surgeries that were not listed above.	

YES	NO	Questions	Further Details
		Do you Smoke?	If so, how much?
		Do you Drink Alcohol?	If so, how much?
		Do you use Illegal Drugs?	If so, what kind? How much?
		Are you Pregnant?	If so, how many months?
		Have you had Surgeries?	If so, list type and date.
		Do you take Medications?	If so, list type, dosage, and reason for taking (include over-the-counter medications as well as herbal supplements) <May add a separate page if necessary>
		Do you have Allergies to Medications?	If so, list type of medication and reaction. <May add a separate page if necessary>

Heartland Podiatry, PC

MEDICAL HISTORY: *Continued*

Patient Name: _____ **Date of Birth:** _____

Pharmacy Name: _____ **Pharmacy Phone #:** _____

Pharmacy (Address): _____

Pharmacy (City, State, Zip): _____

Please Check "Yes" or "No" to indicate if you currently have or had any of the following:

YES	NO	Nature of Problem	Approx. Date of Onset	Comments
		Anemia		
		Arthritis		
		Bleeding Tendency		
		Circulation		
		Diabetes		
		Fainting/ Convulsions		
		Gout		
		Hay Fever/Asthma		
		Heart Problems		
		High Blood Pressure		
		HIV Positive/AIDS		
		Kidney Disease		
		Liver Disease		
		Low Back Pain		
		Numbness in Feet/ Legs		
		Psychiatric		
		Scarring Tendency		
		Skin		
		Stomach/Digestive		
		Strokes		
		Thyroid		
		Flu Vaccine		
		Pneumonia Vaccine		

YES	NO	Questions	Further Details
		Do you have other Conditions not listed above?	If yes, describe.

2406 E. RD Mize Road
Independence, MO 64057
816-478-3338: ph
816-373-0054: fax

6675 Holmes Road, Suite 330
Kansas City, MO 64131
816-444-1100: ph
816-444-1475: fax

2000 SE Blue Parkway, Suite 120
Lee's Summit, MO 64063
816-444-1100: ph
816-444-1475: fax

Authorization for Release of Information—Compound Release

Name of Patient: _____ **Date of Birth:** _____

Heartland Podiatry, PC is authorized to release protected health information about the above named patient in the following manner and to identified persons.

May we leave a voice mail for you that includes sensitive information? ☐ **YES** ☐ **NO**
(If yes, please list the phone number where a message may be left.)
_____

May we discuss your information with others such as a Spouse or Parent?
(If yes, please provide name and phone number below and select applicable box(es) to the right.)

NAME	PHONE NUMBER	
_____	_____	☐ **Financial** ☐ **Medical**
_____	_____	☐ **Financial** ☐ **Medical**
_____	_____	☐ **Financial** ☐ **Medical**

May we send you information via email?*
(If yes, please provide email address below and select applicable box(es) to the right.)
_____
** For email communications to occur, accept the disclosure below:*

☐ **Financial** ☐ **Medical**
☐ **Appointment Reminders**
☐ **Breach Notification**

May we send you information via text message?*
(If yes, please provide phone number below and select applicable box(es) to the right.)
_____
** For text communications to occur, accept the disclosure below:*

☐ **Appointment Reminder**
☐ **Other:** _____

☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

☐ **May we use photos received by you?** ***(If yes, how may we use them? Select applicable box(es) to the right.)***
☐ **Post in Office** ☐ **Post on Website**
☐ **Other:** _____

☐ **With prior verbal notification, may we take photos of you?**
Example: Pre/Post Procedure (If yes, how may we use them? Select applicable box(es) to the right.)
☐ **Post in Office** ☐ **Post on Website**
☐ **Other:** _____

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____ **Date:** _____
Signature of Patient or Personal Representative
*Description of Personal Representative's Authority (attach necessary documentation)

2406 E. RD Mize Road
Independence, MO 64057
816-478-3338: ph
816-373-0054: fax

1161 SE Oldham Pkwy
Lee's Summit, MO 64061
816-478-3338: ph
816-373-0054: fax

HEARTLAND PODIATRY, PC
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*** You May Refuse to Sign this Acknowledgement ***

I, _____, have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Address: _____

City, State, Zip: _____

Date: _____

FOR OFFICE USE ONLY

We have attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

	An emergency existed and a signature was not possible at the time.
	The individual refused to sign.
	A copy was mailed with a request for a signature by return mail.
	Unable to communicate with the patient for the following reason:
	Other (Please specify):

Prepared by: _____

Signature: _____

Date: _____