Ryan J. McCalla, D.P.M.
Christopher M. Brodine, D.P.M.

Advanced
FOOT CARE CENTER
www.topekafootcare.com

Phone: 785-354-7608
Fax: 785-354-4202

PLEASE PRINT AND COMPLETE ALL INFORMATION

PATIENT INFORMATION

Patient Name (First, Initial, Last)	DOB / /	Social Security Number - -
Address		
City, State, Zip		
Home Phone # ( ) -	Cell Phone # ( ) -	Email Address

Patient Primary Language: ☐ English ☐ Spanish ☐ Other	Patient Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Patient Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander	
Gender: ☐ Male ☐ Female	Marital Status : M S D W
Primary Care Physician (PCP)	Date Last Seen

EMERGENCY CONTACT

Contact's Name (First, Last)		Relationship to Patient
Home Phone #	Work Phone #	Cell Phone #

Primary Insurance Subscriber Information (If patient is not primary on account)

Name	Relationship to Patient	
Address (If different than above)	Social Security # - -	DOB / /
City, State, Zip		

CONSENT FOR TREATMENT AND FINANCIAL ARRANGEMENTS

I, the undersigned certify that I (or my dependent) have coverage with the above insurance company. I assign directly to the treating physician all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I further understand that the policy of Advanced Foot Care Center and its physicians is that the parent who requests the treatment of a minor is responsible for all the fees for the services rendered. I authorize Advanced Foot Care Center and/or treating physician to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient or Responsible Party Signature	If Not Patient-Relationship	Date

FOR OFFICE USE ONLY

CHART #:

PATIENT NAME:

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FAMILY HISTORY (please check any that apply to you or a family member)

No Known Medical History □ (Please check this box if you are not aware of any family history listed below).

If this applies to a family member please indicate whether it is Mother or Father by checking **M** or **F** in the box provided.

AIDS/HIV	□ Self	□ M	□ F	Immunodeficiency	□ Self	□ M	□ F
Alcoholism	□ Self	□ M	□ F	Kidney Problems	□ Self	□ M	□ F
Anemia	□ Self	□ M	□ F	Liver Disease	□ Self	□ M	□ F
Artificial Valve	□ Self	□ M	□ F	Neurological Disease	□ Self	□ M	□ F
Artificial Joint	□ Self	□ M	□ F	Neuropathy	□ Self	□ M	□ F
Asthma	□ Self	□ M	□ F	Phlebitis	□ Self	□ M	□ F
Back Problems	□ Self	□ M	□ F	Psoriasis	□ Self	□ M	□ F
Bleeding Disorders	□ Self	□ M	□ F	Psychiatric Care	□ Self	□ M	□ F
Cancer	□ Self	□ M	□ F	PVD / PAD	□ Self	□ M	□ F
Chest Pain	□ Self	□ M	□ F	Radiation Treatment	□ Self	□ M	□ F
Circulatory Problems	□ Self	□ M	□ F	Rash/Skin Disorders	□ Self	□ M	□ F
Depression	□ Self	□ M	□ F	Rheumatoid Arthritis	□ Self	□ M	□ F
Diabetes	□ Self	□ M	□ F	Reynaud's Disease	□ Self	□ M	□ F
Epilepsy	□ Self	□ M	□ F	Respiratory Disease	□ Self	□ M	□ F
Fibromyalgia	□ Self	□ M	□ F	Shortness of Breath	□ Self	□ M	□ F
Foot or Leg Cramps	□ Self	□ M	□ F	Stomach/GI Ulcers	□ Self	□ M	□ F
Feet/Ankles Swelling	□ Self	□ M	□ F	Stroke	□ Self	□ M	□ F
Gout	□ Self	□ M	□ F	Thyroid Disease	□ Self	□ M	□ F
Heart Disease	□ Self	□ M	□ F	Tuberculosis	□ Self	□ M	□ F
Hepatitis	□ Self	□ M	□ F	Varicose Veins	□ Self	□ M	□ F
High Blood Pressure	□ Self	□ M	□ F	Other:_____	□ Self	□ M	□ F
Other:_____	□ Self	□ M	□ F	Other:_____	□ Self	□ M	□ F

MEDICATIONS (list any prescription, vitamins or over the counter medicines that you are taking) IF YOU HAVE A LIST WE CAN TAKE A COPY

No Medications □ (Please check box if you are currently not taking any medications).

Please List Medications:

SURGICAL HISTORY (list any past surgical procedures)

No previous Surgeries □ (Please check box if you have no information to list).

Please List Previous Surgeries:

ALLERGIES (please check or list <u>any</u> type of allergies you may have)

☐	No Known Allergies	☐	Other _____		
☐	Adhesive Tape	☐	Cortisone	☐	Penicillin
☐	Aspirin	☐	Iodine Dye	☐	Sulfa Drugs
☐	Codeine	☐	Latex	☐	Lidocaine

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PATIENT SOCIAL HISTORY

Cigarettes	☐ Yes	☐ No	Caffeine	☐ Yes	☐ No
Other Tobacco	☐ Yes	☐ No	Illegal Drug Use	☐ Yes	☐ No
Alcohol	☐ Yes	☐ No			

REFERRAL SOURCE

How did you hear of us?

Whom may we thank for referring you?

CONTACT PREFERENCES

What is the best way to reach you?

- ☐ Home Phone
- ☐ Work Phone
- ☐ Cell Phone
- ☐ Email

Is it okay to leave a message with:

- ☐ Patient Only
- ☐ Patient and/or spouse
- ☐ Anyone answering the phone

PATIENT OFFICE NOTES

Would you like your office notes sent to your primary care physician or other doctor? ☐ Yes ☐ No

Is there anyone you authorize us to disclose your protected health information to? ☐ Yes ☐ No

If so, to whom do you authorize us to share your information with?

Patient or Responsible Party Signature	If not patient, Relationship	Date

For Medicare Patients Only

Medicare Authorization

I request that payment of authorized Medicare benefits be made on my behalf to the treating physician for services furnished to me by that physician. I authorize information to be released to the Centers for Medicare and Medicaid Services and its agents to determine benefits or the benefits payable for related services. If "other health insurance" is indicated, my signature authorized releasing information to that insurer or agency.

Patient or Responsible Party Signature	If Not Patient-Relationship	Date