FOOT PAIN CENTER OF KANSAS CITY

Jacob B. Goldstein, DPM
230-C East Main Street
Gardner, KS 66030

TODAY'S DATE _____

PATIENT INFORMATION

Patient's Full Name _____Preferred Name_____

Marital Status (circle) Single Married Widowed Divorced Gender (circle) Male Female

Due to new federal government requirements, please check the following for the patient being seen:

Race: ❒African American ❒Native American ❒Asian ❒Pacific Islander-Hawaiian ❒Caucasian-White ❒Decline to Report

Ethnicity: ❒Hispanic ❒Latino ❒Not Hispanic-Not Latino ❒Other _____

Preferred Language ❒ English ❒ Spanish ❒French ❒Other _____

Social Security # _____ Birth Date _____ Age _____

Street Address _____ Home Phone _____

City, State, Zip _____ Work Phone _____

E-Mail Address _____ Cell Phone _____

*** Please circle preferred method of contact**

Employer _____ Occupation _____

Employer Address_____

RESPONSIBLE PARTY OR NAME UNDER INSURANCE ❒ Same as above

Name _____ Relationship to Insured _____

Social Security # _____ Birth Date _____ Home Phone _____

Street Address _____ City, State, Zip _____

Employer _____ Employer Address _____

MEDICAL INFORMATION Primary Care Doctor _____

Date of Last Visit to Doctor _____ Pharmacy & Location _____

In case of emergency, please call _____ Relationship _____ Phone _____

Permission to disclose/discuss my Health Information, Test results, Office/Financial information

I understand that the authorization is **voluntary.** I understand that I may refuse to sign this authorization and my treatment and/or payment obligations will not be affected. I understand that I may revoke this authorization at any time by notifying The Foot Pain Center of Kansas City in writing and it will not have any effect on uses or disclosures prior to the receipt of the revocation.

I herby authorize *The Foot Pain Center of Kansas City* to use and disclose health information to the following:

Name: _____ Relationship: ❒ Spouse ❒ Relative ❒ Friend ❒ Power of Attorney

MEDICAL INSURANCE Co-Pay $_____ ❒ PPO ❒ HMO ❒ MEDICARE

Primary Company _____ Secondary Company _____

Subscriber _____ Subscriber _____

Certificate # _____ Certificate # _____

Group# _____ Group # _____

REFERRAL INFORMATION Please take a moment to tell us how you found out about our practice.

❒ My family doctor, Dr. _____
❒ Another doctor, Dr. _____
❒ Patient from this practice _____
❒ Phone Book (City/Directory) _____
❒ Internet search/Website
❒ Hospital' s referral network _____
❒ Insurance booklet
❒ Other _____