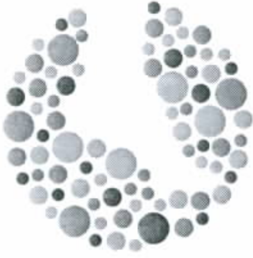

9300 MEADOW VIEW DR, STE 101
LENEXA, KS 66227
PHONE (913)871-2183
FAX (913)780-4834

INSURANCE PAYMENT ORDER

TO:____
(INSURANCE COMPANY)

ADDRESS:____

I hereby authorize you to pay directly to the below named doctor, benefits due me out of indemnity under the terms of my policy issued by your company:

JAYHAWK FOOT & ANKLE CLINIC
9300 MEADOW VIEW DR, STE 101
LENEXA, KS 66227

Payment is authorized upon your receipt of his itemized statement for services rendered to me. This policy was in full force and effect at the time of these services were rendered. Payment of this amount as herein directed, in whole or part, shall be considered the same as if paid by your company, directly to me.

INSURED______________________________ POLICY NO. ______________________

ADDRESS ____

LEGAL SIGNATURE______________________________ DATE ______________________
(IF INSURED IS A MINOR, PARENT OR GUARDIAN MUST SIGN)

PATIENT FINANCIAL OBLIGATION

Patient Name: ____

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 balanced thereof.

______________________________ ______________

Signature Date

JAYHAWK
FOOT & ANKLE CLINIC

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) e-mail 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:

____

(Office use only)

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

9300 MEADOW VIEW DR, STE 101
LENEXA, KS 66227 PHONE
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NAME OF PATIENT ____________________
FIRST MIDDLE LAST

ADDRESS ____________________

CITY ____________ STATE ____________ ZIP CODE ____________

DATE OF BIRTH ____________ AGE ____________ SEX ____________

PATIENT'S SOCIAL SECURITY # ____________________

☐ MARRIED ☐ UNMARRIED SPOUSE'S/PARENT'S/GUARDIAN'S NAME(S) ____________

HOME PHONE ____________ CELL PHONE ____________

WORK PHONE ____________ EMAIL ____________
If providing a phone number of someone else besides the patient, please provide person's name

PREFERRED METHOD OF CONTACT: ☐ Home # ☐ Cell # ☐ Work # ☐ Email

RACE: ____________________
AMERICAN INDIAN OR ALASKAN NATIVE (I); ASIAN (A); BLACK (B); CAUCASIAN (C); OTHER (E); PACIFIC ISLANDER (P); DECLINED (D)

ETHNICITY: ____________ LANGUAGE: ____________
HISPANIC (H) OR NON-HISPANIC (N)

EMPLOYER OF PATIENT ____________________

INSURANCE COMPANY NAME ____________________

SUBSCRIBER NAME ____________________

POLICY # ____________ GROUP # ____________

SUBSCRIBER SOCIAL SECURITY # ____________________

SUBSCRIBER BIRTHDATE ____________________

EMPLOYER OF SUBSCRIBER ____________ WORK PHONE ____________

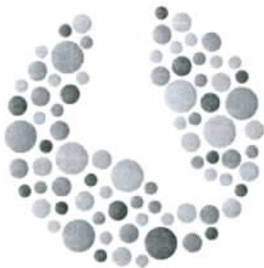
SECONDARY INSURANCE COMPANY NAME ____________________

SUBSCRIBER NAME ____________ POLICY # ____________ GROUP # ____________

REFERRED BY: ____________ FAMILY PHYSICIAN: ____________

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.

DATE: ____________ SIGNATURE: ____________



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

Patient Name:__________________________________**Birthdate:**________________

Describe your foot problem:____

____

____

How long has this been bothering you?________Days________Weeks________Years

Any past problems with your feet or ankles?_______________________________

____

____

Any past surgeries on your feet or ankles?________________________________

____

____

Shoe size:__________ Current weight:__________ Height:____________ Age:________

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)________________

Yes___________ No____________ Reaction:________________

Have you had any problems with local anesthetics (Novocaine, Lidocaine, Marcaine)

Yes___________ No____________ Reaction: ________________

General Health Information:

Do you have diabetes? Yes____ No____ If yes, what medicine do you take (include dosage)?

______________________________________Number of years:______________

Have you had any serious illnesses?____

Have you had any major surgeries?____

Are you under a physician's care? Yes______ No______ If yes, for what condition_______

____

Family physician:______________________Phone Number:___________________

Date you last saw your doctor:____

May we contact your doctor about your health?_________If no explain why:__________

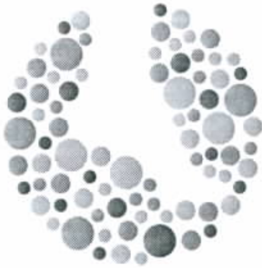
____

Name of your pharmacy:_______________________Phone#___________________

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

____

Signature:____________________________ **Date:**___________________________



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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
( )Stomach Ulcers	( )Gout	( )Arthritis
( )Hormones	( )Tuberculosis	( )Healing
( )Skin	( )Unexplained Weight Loss	( )Kidneys
( )Frequent Infections	( )Anemia	( )Lungs
( )Rheumatic Fever	( )Neurological Disorder	( )Bladder
( )Cancer	( )High Blood Pressure	

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 of:

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

Signature:___________________________________**Date:**__________________