FOOT PAIN CENTER OF KANSAS CITY
Jacob B. Goldstein, DPM

TODAY'S DATE _____

PATIENT INFORMATION
Patient's Full Name _____Preferred Name_____

Marital Status (circle) Single Married Partnered 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 _____
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 prior uses or disclosures.

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 Primary Company _____ Co-Pay $_____ ❒ PPO ❒ HMO
Subscriber _____ Secondary Company _____

Subscriber _____

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 _____

Appointment Reminder Consent I authorize Foot Pain Center of Kansas City to remind me by voice mail, text message, or e-mail of future appointments. I understand that my telephone number will not be used for any solicitation. I understand that I have the option to stop these reminders at any time by notifying the Foot Pain Center of Kansas City.

Signature: _____ Date: _____