St. Joseph Foot Clinic

1005A West St. Maartens Drive, St. Joseph, MO 64506
Telephone (816) 364-2338

PLEASE COMPLETE ALL INFORMATION AND BRING TO THE OFFICE AT THE TIME OF YOUR APPOINTMENT.

Your Appointment _____

Dr. Lipira ❑ Dr. Grimes ❑ Dr. Olsen ❑

(Please Print)

Patient's Name: Last _____ First _____ Middle _____

Address: Street _____ Apt. No. _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Date of Birth _____ ( ) M Sex: ( ) F SS # _____

Employer _____ Occupation _____ Employer's Address _____

City _____ State _____ Zip _____ Work Phone _____

PLEASE COMPLETE THE SECTION BELOW IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR ACCOUNT*

Relationship to Patient: ( ) Spouse ( ) Parent ( ) Other _____

Name: Last _____ First _____ Middle _____

Address: Street _____ Apt. No. _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Social Security # _____

Employed By _____ Employer's Address _____

City _____ State _____ Zip _____ Bus. Phone _____

MEDICAL INSURANCE INFORMATION: Please give us all pertinent information regarding your insurance coverage. If you have coverage by more than one carrier, please supply information for all.

***IMPORTANT:* IF YOUR INSURANCE REQUIRES A REFERRAL, *YOU* MUST OBTAIN IT FROM YOUR PRIMARY DOCTOR BEFORE YOUR APPOINTMENT HERE!!**

I Primary Ins. _____

Address _____

Policy or Ctf. No. _____ Group No. _____

II Secondary Ins. _____

Address _____

Policy or Ctf. No. _____ Group No. _____

PLEASE COMPLETE IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR INSURANCE COVERAGE*

Insured:
Last Name _____ First _____ MI ___

Address: Street _____ Apt. No. ___

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Date of Birth _____ Sex: ( ) M ( ) F

Employer _____

Social Security # _____

Insured:
Last Name _____ First _____ MI ___

Address: Street _____ Apt. No. ___

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Date of Birth _____ Sex: ( ) M ( ) F

Employer _____

Social Security # _____

MISCELLANEOUS INFORMATION:

Patient Status: ( ) Married ( ) Single ( ) Widow/Widower ( ) Divorced ( ) Other ( ) Full-Time Student ( ) Part-Time Student

Employment: ( ) Full Time ( ) Part Time ( ) Retired ( ) Unemployed ( ) Disability

CONTACT IN CASE OF EMERGENCY _____

LIFETIME CONSENT

Insurance Authorization: Medicare, Medigap and All Others

I request that payment be made to the St. Joseph Foot Clinic on my behalf for any services furnished to me by the participating physician. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services. I permit a copy of this authorization to be used in place of the original. In the event my account is in default and placed for collection, I understand that I will be responsible for all reasonable cost of collection and attorney fees.

X _____ Date _____

ST. JOSEPH FOOT CLINIC
PATIENT HISTORY

PLEASE COMPLETE ALL INFORMATION AND BRING TO THE OFFICE AT THE TIME OF YOUR APPOINTMENT.

NAME:_____ BIRTHDATE:_____ DATE: _____

FAMILY PHYSICIAN:_____ OTHER PHYSICIAN: _____

REFERRED BY:_____ PREVIOUS PODIATRIST:_____

PATIENT STATUS:
( ) Married ( ) Single ( ) Widow/Widower ( ) Divorced ( ) Full-Time Student ( ) Part-Time Student HEIGHT: _____ WEIGHT: _____

ARE YOU PRESENTLY UNDER THE CARE OF A PHYSICIAN? _____

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR ILLNESSES? CHECK IF YES:

- ☐ ACID REFLUX
- ☐ ARTHRITIS
- ☐ ASTHMA/BREATHING PROBLEMS/COPD
- ☐ BACK PROBLEMS
- ☐ BLEEDING PROBLEMS
- ☐ CANCER
- ☐ DEPRESSION/ANXIETY
- ☐ DIABETES
- ☐ FIBROMYALGIA
- ☐ GLAUCOMA
- ☐ GOUT
- ☐ HEART TROUBLE
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ KIDNEY TROUBLE
- ☐ LIVER PROBLEMS OR HEPATITIS
- ☐ MACULAR DEGENERATION
- ☐ NEUROPATHY
- ☐ OSTEOPOROSIS
- ☐ PHLEBITIS (BLOOD CLOT)
- ☐ POOR CIRCULATION
- ☐ RHEUMATIC FEVER
- ☐ SEIZURES
- ☐ SLEEP APNEA
- ☐ STOMACH ULCER
- ☐ STROKE
- ☐ TIA
- ☐ THYROID PROBLEMS
- ☐ TUBERCULOSIS

OTHER DISEASES OR ILLNESSES **LIST**: _____

_____

PAST INJURIES: ___ NO ___ YES **LIST**: _____

_____

PAST SURGERIES: ___ NO ___ YES **LIST**: _____

_____

ANESTHESIA PROBLEMS?: ___ NO ___ YES **LIST**: _____

FAMILY HISTORY OF DIABETES? ___ NO ___ YES **LIST**: _____

OTHER FAMILY ILLNESSES: **LIST**; _____

OCCUPATION:_____ RETIRED: ___ NO ___ YES STUDENT: ___ NO ___ YES

DO YOU CONSUME ALCOHOL? ___ NO ___ YES AMOUNT: _____

DO YOU USE TOBACCO? ___ NONE ___ CIGARETTES ___ PACKS/DAY ___ YEARS ___ CIGARS ___ PIPE ___ SMOKELESS

PRESENT MEDICATIONS/DRUGS: **LIST**: _____

_____

_____

ALLERGIES TO MEDICATIONS: **LIST**: _____

_____

_____

WOMEN OF CHILD BEARING AGE - ANY POSSIBILITY OF PREGNANCY? ___ NO ___ YES

YOUR CHIEF COMPLAINT - EXPLAIN IN YOUR OWN WORDS: _____

_____

HOW LONG?_____ IS THIS THE RESULT OF AN INJURY? ___ NO ___ YES ___ AT HOME ___ AT WORK

I.C. *(OFFICE USE ONLY)* _____