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

www.topekafootcare.com

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

PLEASE PRINT AND COMPLETE ALL INFORMATION

PATIENT INFORMATION

Patient Name (First, Initial, Last)		Home Phone #	Cell Phone	
Address	Social Security #	DOB	☐ Male ☐ Female	Marital M S D W
City, State, Zip		Email Address		
Employer	Employer Phone #	Primary Care Physician (PCP)		
Employer Address	City, State, Zip	Date Last Seen		

GUARANTOR INFORMATION (parent info if patient is a minor, or person responsible for account)

Name (First, Initial, Last)	Relationship	Phone #
Address		Social Security #
City, State, Zip		Date of Birth
Employer		Employer Phone #
Employer Address		City, State, Zip

EMERGENCY CONTACT

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

INSURANCE INFORMATION (We will also need a copy of your insurance card)

Primary Insurance Company	Name of Card Holder	
Relation to Patient	Card Holder DOB	SSN of Card Holder
Secondary Insurance Company	Name of Card Holder	
Relation to Patient	Card Holder DOB	SSN of Card Holder

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:

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

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

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

Condition	Self	Family	Condition	Self	Family
AIDS/HIV	☐ Self	☐ Family	Hepatitis	☐ Self	☐ Family
Anemia	☐ Self	☐ Family	High Blood Pressure	☐ Self	☐ Family
Arthritis	☐ Self	☐ Family	Immunodeficiency	☐ Self	☐ Family
Artificial Valve	☐ Self	☐ Family	Kidney Problems	☐ Self	☐ Family
Artificial Joint	☐ Self	☐ Family	Liver Disease	☐ Self	☐ Family
Asthma	☐ Self	☐ Family	Neurological Disease	☐ Self	☐ Family
Back Problems	☐ Self	☐ Family	Phlebitis	☐ Self	☐ Family
Bleeding Disorders	☐ Self	☐ Family	Psychiatric Care	☐ Self	☐ Family
Cancer	☐ Self	☐ Family	Radiation Treatment	☐ Self	☐ Family
Chest Pain	☐ Self	☐ Family	Rash/Skin Disorders	☐ Self	☐ Family
Circulatory Problems	☐ Self	☐ Family	Respiratory Disease	☐ Self	☐ Family
Depression	☐ Self	☐ Family	Shortness of Breath	☐ Self	☐ Family
Diabetes	☐ Self	☐ Family	Stroke	☐ Self	☐ Family
Epilepsy	☐ Self	☐ Family	Swollen Neck Glands	☐ Self	☐ Family
Foot or Leg Cramps	☐ Self	☐ Family	Thyroid Disease	☐ Self	☐ Family
Feet/Ankles Swelling	☐ Self	☐ Family	Tuberculosis	☐ Self	☐ Family
Gout	☐ Self	☐ Family	Stomach/GI Ulcers	☐ Self	☐ Family
Headaches	☐ Self	☐ Family	Varicose Veins	☐ Self	☐ Family
Heart Disease	☐ Self	☐ Family			

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 any type of allergies you may have)

☐ No Known Allergies

☐ Adhesive Tape	☐ Cortisone	☐ Penicillin
☐ Aspirin	☐ Iodine Dye	☐ Sulfa Drugs
☐ Codeine	☐ Latex	☐ Lidocaine

OTHER:

FOR OFFICE USE ONLY

CHART #:

PATIENT NAME:

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PATIENT INFORMATION

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

PATIENT SOCIAL HISTORY

Cigaretts	☐ 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

If so, to whom would you like them sent?

Patient or Responsible Party Signature	If not patient, Relationship	Date

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