

**Mid-America Foot & Ankle Specialists P.C.**

*Chris R. Guerrieri, DPM*

*James J. Good, DPM*

*Jennifer B. Halligan DPM*

**WELCOME TO OUR OFFICE**

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ Social Security # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Sex: M / F Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Marital Status: S M D Widow/er

**Who may we thank for referring you to our office?** Doctor: \_\_\_\_\_ Friend \_\_\_\_\_  
Yellow Pages \_\_\_\_\_ Newspaper Ad \_\_\_\_\_ Insurance Directory \_\_\_\_\_ Other: \_\_\_\_\_

Home Telephone # \_\_\_\_\_ Work Telephone # \_\_\_\_\_ Cell # \_\_\_\_\_  
Patient Employed By \_\_\_\_\_ Occupation \_\_\_\_\_  
Work Type: Sitting / Semi-Active / Active Shoe Wear Restrictions? \_\_\_\_\_

Insurance #1: \_\_\_\_\_ Subscriber: \_\_\_\_\_ Policy#: \_\_\_\_\_  
Group #: \_\_\_\_\_ DOB (Insured): \_\_\_\_\_  
Insurance #2: \_\_\_\_\_ Subscriber: \_\_\_\_\_ Policy#: \_\_\_\_\_  
Group #: \_\_\_\_\_ DOB (Insured): \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse Employed By \_\_\_\_\_ Phone \_\_\_\_\_  
Emergency Contact/Guardian if patient is a minor \_\_\_\_\_

**AUTHORIZATIONS ----\*\*\*YOU MUST COMPLETE THIS SECTION\*\*\***

\_\_\_ Yes \_\_\_ No I hereby authorize benefits directly to the physician of the surgical and/or medical benefits.

\_\_\_ Yes \_\_\_ No I understand I am responsible for any portion of my bill not covered by my insurance company.

\_\_\_ Yes \_\_\_ No I HEREBY AUTHORIZE RELEASE OF INFORMATION AND/OR MEDICAL RECORDS OF MYSELF TO ANY TREATING PHYSICIAN OR INSURANCE COMPANY.

\_\_\_ Yes \_\_\_ No The information authorized for release may include information which may be considered a Communicable or venereal disease, including hepatitis, syphilis, gonorrhea, HIV or AIDS.

\_\_\_ Yes \_\_\_ No I voluntarily request Drs. Guerrieri, Good and Halligan, and such associates, assistants and other health care providers as they deem necessary, to treat my condition.

\_\_\_\_\_ Yes, I understand I may be subject to a **\$25 fee for appointments not cancelled 24 hrs in advance.**

\_\_\_\_\_ Yes, I have been informed of, and given a chance to review a copy of this office's HIPAA policy.

I understand all of the above and hereby state that the information is correct to the best of my knowledge.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient

## MEDICAL INFORMATION

Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_ Previous Podiatrist: \_\_\_\_\_  
 Family Physician \_\_\_\_\_ Date of Last Physical: \_\_\_\_\_

**What is your foot/ankle problem?** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

How Long Has This Been a Problem? \_\_\_\_\_

Have You Had Any Treatment? \_\_\_\_\_

### Please Indicate Where Your Problem is Located



### Personal and Family Medical History

List personal and family medical conditions, use space below to add additional conditions.

|                         | You | Father | Mother | Sibling | Children | Additional Info |
|-------------------------|-----|--------|--------|---------|----------|-----------------|
| Arthritis               |     |        |        |         |          |                 |
| Diabetes                |     |        |        |         |          |                 |
| Foot problems           |     |        |        |         |          |                 |
| Blood Clots / DVT       |     |        |        |         |          |                 |
| Circulation Problem     |     |        |        |         |          |                 |
| Heart disease           |     |        |        |         |          |                 |
| Deceased (Indicate Age) | N/A |        |        |         |          |                 |

Please list other Medical Problems:

**Surgeries and Hospitalizations**

List ALL previous surgeries and hospitalizations, dates and reasons.

| Previous Surgeries/Hospitalizations | Approximate Dates | Reason |
|-------------------------------------|-------------------|--------|
|                                     |                   |        |
|                                     |                   |        |
|                                     |                   |        |

**Medications**

Please list ALL medications (with dosage). **Include non-prescription, herbs and supplements.**

| Name of Medication | Reason for Taking it | How Often Do You Take It? |
|--------------------|----------------------|---------------------------|
|                    |                      | Once a day    Twice a day |
|                    |                      | Once a day    Twice a day |
|                    |                      | Once a day    Twice a day |
|                    |                      | Once a day    Twice a day |
|                    |                      | Once a day    Twice a day |
|                    |                      | Once a day    Twice a day |
|                    |                      | Once a day    Twice a day |

**Allergies**

| Medication / Food | Reactions |
|-------------------|-----------|
|                   |           |
|                   |           |
|                   |           |

**Social History**

|                             | Never | Occas. | Frequent |
|-----------------------------|-------|--------|----------|
| Herbal Supplements          |       |        |          |
| Alcohol                     |       |        |          |
| Tobacco (packs/day & years) |       |        |          |

**Review of Systems** (doctor will ask)

General:                      Cardio:                      Resp:                      Ortho:                      Other:

# Mid-America Foot and Ankle Specialists, P.C.

2800 NE 60th St  
Gladstone, MO 64119

550 Rush Creek Pkwy  
Liberty, MO 64068

PH: 816-453-5161  
FAX: 816-453-5874

**Dr. Chris Guerrieri**

**Dr. James Good**

**Dr. Jennifer Halligan**

## Release of Information

Due to patient confidentiality concerns, Mid America Foot and Ankle Specialists, would like to know to whom we have permission to release information regarding your appointments and care, bills, and/or test results. This consent is good for one calendar year.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I give permission for Mid America Foot and Ankle Specialists, to release my information to:

1. \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone: \_\_\_\_\_
2. \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone: \_\_\_\_\_
3. \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone: \_\_\_\_\_
4. \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone: \_\_\_\_\_
5. \_\_\_\_\_ Relationship: \_\_\_\_\_

I do not wish to have any of my information released to anyone other than myself: \_\_\_\_\_

This consent is valid for all test results unless we are otherwise notified in writing not to release any information to someone other than myself.

Messages may be left on an answering machine at home as long as we are sure that it is the correct number. If you circle NO, then results may be mailed to you if we cannot reach you by phone.

YES

NO

Signature \_\_\_\_\_ Date \_\_\_\_\_