Kurt Kinghorn, DPM, AACFAS
Ph: (208) 344-3324
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Millennium Medical Park
1828 S Millennium Way
Meridian, Idaho 83642

Anderson Plaza
222 N 2nd St Suite 301
Boise, ID 83702

St. Luke's Elmore
840 N 4th East
Mountain Home, Idaho 83647

PATIENT INFORMATION:

Last Name: _____ First: _____ MI: _____

What name do you prefer? _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email: _____

TELEPHONE NUMBERS:

Home: (_____) _____

Work: (_____) _____

Cell: (_____) _____

Emergency Contact: _____

Emergency Phone: (____) _____

PRIMARY CARE PHYSICIAN:

Doctor: _____

Phone: (_____) _____

City: _____ State_____

Date Last Seen: ____/____/_____

PATIENT IDENTIFICATION:

Social Security #: ____-_____-_____

DOB: ____ / ____ / _____

Gender: M F

SPOUSE/ PARENT IDENTIFICATION:

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

SSN#: ____-____-____ DOB: ___/___/_____

Pharmacy: _____ Pharmacy ph. #: _____

Pharmacy Cross Streets: _____

PATIENT EMPLOYMENT:

Employer: _____ Occupation: _____ Phone #: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Is your problem due to an accident at work? Y N Date of Accident: ___ / ___ / _____

What caused it? _____

INSURANCE INFORMATION:

PRIMARY INSURANCE:_____

ADDRESS:_____

CITY: _____STATE: _____ ZIP: _____

POLICY HOLDER: _____

DOB # ____/____/_____

RELATIONSHIP TO POLICY HOLDER: _____

POLICY #: _____ GROUP #: _____

PHONE #: (____) _____ COPAY: _____ EFFECTIVE DATE: __/___/____

SECONDARY INSURANCE:_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

POLICY HOLDER: _____

DOB # ___/___/_____

RELATIONSHIP TO POLICY HOLDER: _____

POLICY #: _____ GROUP #: _____

PHONE #: (____) _____ COPAY: _____ EFFECTIVE DATE: ___/__/____

DRIVERS LICENSE #: _____ STATE: _____ EXP DATE: ___/___/____

Dr. Kinghorn will bill all charges to my insurance carrier as a courtesy; however, I understand that I am ultimately responsible for payment of services regardless of insurance coverage. If my account is referred to a collection agency, I understand that I am responsible for collection fees and any legal fees that are incurred by the action.

PATIENT / GUARDIAN SIGNATURE: _____

DATE: ____/____/_____

PATIENT NAME: _____ DOB: _____/____/_____

Primary Dr: _____Pharmacy # & Cross St: _____

PATIENT HEALTH HISTORY

Patient Height: _____ Patient Weight: _____ Patient Shoe Size: _____

Please indicate if **self(S)** or your **family(F)** have or have had any of the following:

		General Medical			Foot /Leg Conditions			Foot Skin Problems
S	F	Diabetes	S	F	Bunions	S	F	Fungus
S	F	Arthritis	S	F	Bone Fracture	S	F	Growths
S	F	Circulation Problems	S	F	Bow Legs	S	F	Hard Corns
S	F	Gout	S	F	Burning	S	F	Soft Corns
S	F	Anemia	S	F	Arch Pain	S	F	Dryness
S	F	Asthma	S	F	Foot Cramps	S	F	Calluses
S	F	Stomach Ulcers	S	F	Unequal Leg Lengths	S	F	Moist Skin
S	F	Hardening of Arteries	S	F	Knee Pain	S	F	**Toe Nail Problems**
S	F	Infection Prone	S	F	Heel Pain	S	F	Fungus
S	F	Bleed Easily	S	F	Knocked Knees	S	F	Thick
S	F	Slow Healer	S	F	Sprains	S	F	Curved
S	F	Heart Trouble	S	F	Low Back Pain	S	F	Ingrown
S	F	Kidney Trouble	S	F	Varicose Veins	S	F	Brittle
S	F	Liver Trouble	S	F	Nerve Injury	S	F	Deformed
S	F	Fainting Spells	S	F	Stiffness	S	F	Discolored
S	F	High Blood Pressure	S	F	Coldness	S	F	Other_____
S	F	Polio	S	F	Numbness	S	F	**Shoe Wear Problems**
S	F	Rheumatic Fever	S	F	Pigeon Toes	S	F	Tip
S	F	Tuberculosis	S	F	Toes Outward	S	F	Heel
S	F	Cancer	S	F	Flat Feet	S	F	Upper
S	F	Epilepsy	S	F	High Arches	S	F	Soles
S	F	Gangrene	S	F	Hammer Toes	S	F	
S	F	Hepatitis	S	F	Leg Cramps	S	F	
S	F	HIV Positive	S	F	Other_____	S	F	

What treatment (including surgeries) have you had for any problems marked above:

_____

List any medications you are taking **AND** their dosages:_____

_____

_____

Drug Allergies: _____

_____

Do you Smoke? Y N (#of packs per day): _____ Quit/Date: _____

Do you drink alcoholic beverages? Y N How much/often: _____

PATIENT NAME: _____ DOB: ____/_____/_____

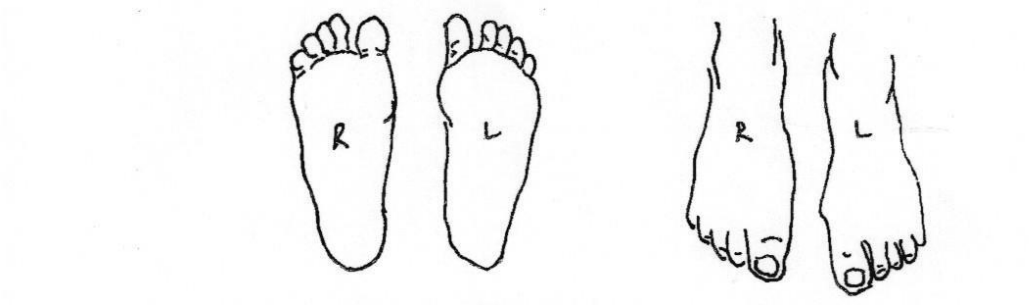
How did you hear about our office? _____

Reason for today's visit? _____

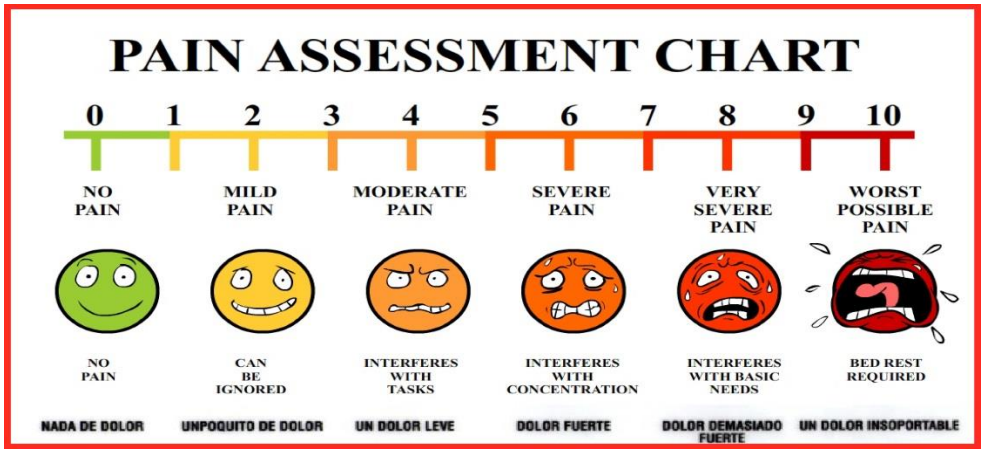
Current problem is the result of a: Check all that apply & date of occurrence:
Car Accident: Y ___ / ___ / _____ Work Accident: Y ___ / ___ / _____ Other:_____

Date symptoms started: ___/___/____

Where is the pain located? (Shade area of foot on diagram)



Please indicate your pain level below



Overall, is the problem getting better, worse or no change? _____

What previous treatment (including surgeries) have you had for this problem?

_____

Did the above treatment help? Yes or No

What treatments have helped? (I.e. aspirin type products, decrease activity, new shoes)

_____

What makes the symptoms worse: (i.e. activity?)

_____

FINANCIAL AGREEMENT

* This office will file insurance claims for all insurance companies. Please provide a copy of your insurance card. You are responsible for knowing the provisions of your policy.
* If your policy requires a referral from your Primary Care Physician, you are responsible for obtaining that referral prior to being seen by Dr. Kinghorn.
* If you do not have insurance coverage or cannot provide proof of insurance, we will give a 20% discount if payment is made in full at time of visit. If it cannot be paid at time of visit we will require 4 equal payments.
* Regardless of insurance coverage, you remain responsible for payment of your account.
* Patients are responsible for their copay/deductible/co-insurance or 20% of total charges at the time of your visit.
* A $25.00 fee will be charged for appointments that are canceled without a 24-hour notice.
* A finance charge of 1.5% per month may be added to accounts more than 60 days old.
* A $15.00 fee will be charged on all returned checks regardless of the reason.

Signature: _____
Date: _____/_____/_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Name (Please Print):

Parent/Guardian Name (If applicable):

Signature: _____

Date: ___ / ___ / _____

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.