Kurt Kinghorn, DPM, AACFAS
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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:

Cell: (_____) _____

Work: (_____) _____

Home: (_____) _____

EMERGENCY CONTACT:

Name: _____

Phone: (_____) _____

Relation: _____

PATIENT IDENTIFICATION:

Social Security #: _____-_____-_____ DOB: _____ / _____ / _____

Gender: M / F Marital Status: Married / Single / Widowed / Divorced

PATIENT EMPLOYMENT:

Employer: _____ Occupation: _____

PHARMACY:

Pharmacy Name: _____ Ph: (_____) _____

Pharmacy Cross Streets & City: _____

FOR PEDIATRIC PATIENTS ONLY – Please complete if patient is a under 18 years of age

Parent/Guardian: _____

Address (if different from above): _____

Date of Birth: ____ / ____ / _____ SSN: ____ / ____ / _____ Relationship: _____

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: ___/____/_____

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.

SIGNATURE OF PATIENT (or responsible party): _____

DATE: ____/____/_____

CONSENT FOR CARE:

You have the right, as a patient, to be informed about your condition & the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks & hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent is simply an effort to obtain permission to perform the evaluation necessary to identify appropriate treatment and/or procedures for any identified condition(s).

_____ _____
Signature of patient or responsible party ***Date***

_____
Printed Name

PATIENT NAME: _____ DOB: _____/ _____/_____

How did you hear about our office? _____

PATIENT HEALTH HISTORY

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

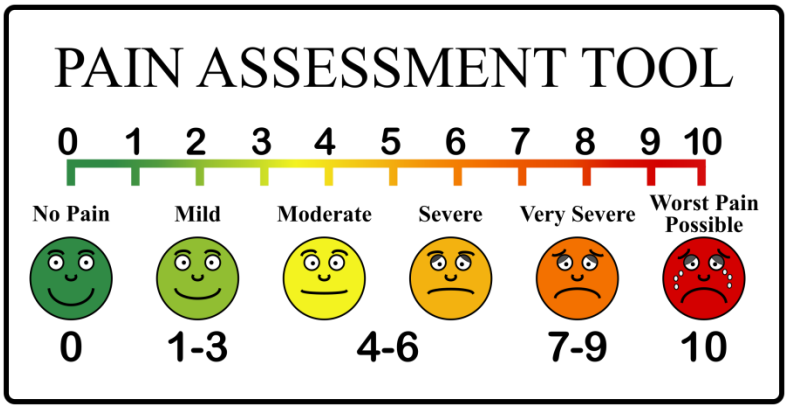
Primary Care Physician: _____ Date Last Seen: _____ / _____

Please describe what brought you in to see the doctor today – **please include which foot/toe & for how long**

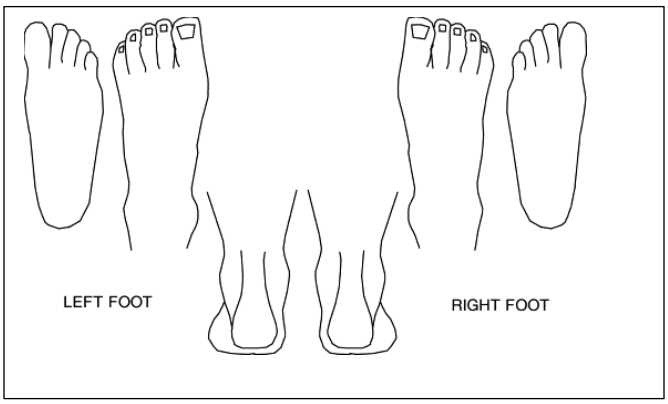
_____

_____

CIRCLE # FOR CURRENT PAIN LEVEL:



CIRCLE or "X" AREA OF CONCERN:



Was this an injury/accident? Yes / No
If yes, have you notified your employer? Yes / No

Work Related? Yes / No
Date of Injury: ____ / ____ / _____

Overall, is the problem getting: better / worse / no change

What previous treatment (including surgeries & at home remedies) have you tried for this problem?

_____

_____

Did the above treatment help? Yes / No / Somewhat

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

_____

How many hours daily are you on your feet? 1-2 2-4 4-6 6-8 8-10 10-12 12-14

DOES THE PATIENT HAVE DIABETES: Yes / No **TYPE:** I / II
Blood sugar this morning: _____ Last HbA1C:_____

When was the last time your HbA1C was tested: _____ / _____ (month/year)

PATIENT NAME: _____ DOB: ____ / ____ / ____

ALLERGIES:	REACTION:

MEDICATION/SUPPLEMENT:	DOSE:	Reason:

Medical Conditions: - Please circle any that apply

AIDS/HIV
Alcoholism
Anemia
Angina
Asthma
Bleeding Disorder
Blood Clots/Thrombosis
Cancer _____
Cerebral Palsy
Chemical Dependency
Cellulitis
Crohn's Disease
Coronary Artery Disease
Cirrhosis of the Liver
COPD
Leg/foot Ulcer
Charcot Marie Tooth
Diabetes
Emphysema
Fibromyalgia
GERD/Peptic Ulcer
Gluten Intolerance
Gout
Heart Disease
Heart Attack
Hemophilia
Hepatitis _____
High Blood Pressure
High Cholesterol
Immune Disorder
Irritable bowel disease
Kidney Disease
Low back pain
Other not listed _____
Low Blood Pressure
Liver Disease
MRSA Infection
Neuropathy
Osteoarthritis
Psoriasis
Psychiatric Illness/BiPolar
Respiratory Disease
Rheumatoid Arthritis
Spine Injury/Deformity
Stroke
Thyroid Disease
Urinary Tract Infections
Venereal Disease
Depression/ Anxiety

Surgical History & Hospitalization History – Please list all surgeries and approximate dates:

_____

_____

Social History	Numbers/Frequency
Do you smoke?	
If Yes, how many packs/day?	
Do you drink alcohol?	
If yes how may per day/week?	

X	Family History	Family Member
	Diabetes	
	Cancer:	
	Heart Disease	
	Stroke	
	Rheumatoid Arthritis	
	Gout	
	Lupus	

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 -6 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 of Patient (or responsible party): _____
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.