

WELCOME TO KIM FOOT & ANKLE CENTERS, INC.

Thanks for becoming a part of our family here at Kim Foot & Ankle Center! We want to get to know all about you and your life so we can provide you with the great care you deserve. **Please complete this packet so we can communicate and educate you on every aspect of your foot health!**

Name you like to be called: _____ **Email Address:** _____

Would you like to receive information/our newsletter via email? Yes No

Your Spouse's Name: _____ **Age:** _____ **Occupation:** _____

Children's Names:

1. _____ **Age:** _____ **Occupation:** _____

2. _____ **Age:** _____ **Occupation:** _____

3. _____ **Age:** _____ **Occupation:** _____

How did you find us: (Please circle all that apply)

Doctor Referral	Friend/Family Referral	Internet Search:
Phone Directory	Insurance Company Directory	Google
KimFoot.Com	Worker's Comp Attorney	Yahoo
TV	BlogTalk Radio Program	Ask.Com
Radio	Dr. Kim Seminar/Talk	Other _____
FaceBook.Com	Twitter.Com	LinkedIn.Com

Hobbies & Interests: (Please circle all that apply)

Art	Fishing	Real estate investment
Automotive work	Gardening	Sailing
Bible/Devot. Reading	Golf	Science/new technology
Camping/Hiking	Hunting/shooting	Sewing
Collectibles/Collect	Motorcycling	Shopping
Community/Civil activity	Music	Sports
Cooking	Needlework/knitting	Travel
Crafts	Photography	Wildlife/environment
Cultural Affairs	Reading	Other _____

Your Favorite Place to Travel: _____

Types of Exercise You Do: (Please circle all that apply)

Aerobics	Hiking/climbing	Pilates	Swimming
Cycling	Kickboxing	Rowing	Weight Training
Elliptical Machine	Martial Arts	Running/Jogging	Yoga
Other _____		How Often Do You Exercise _____	

KIM FOOT & ANKLE CENTERS, INC.

701 E. 28th Street, #111
Long Beach, CA 90806
(562) 426-2551

1246 W. 155th Street
Gardena, CA 90247
Wound Care Center

15506 S. Normandie Ave.
Gardena, CA 90247
(310) 516-9707

NEW PATIENT HISTORY

Patient Name _____ Date _____

Briefly describe your foot problem _____

Duration of this problem _____

Have you been treated for this problem before? _____

Briefly describe past treatment _____

Have you ever had foot surgeries? _____

PAST MEDICAL HISTORY

ADULT DISEASE (please check):

High Blood Pressure: _____ Diabetes _____ Arthritis _____ Hepatitis _____

Anemia _____ Other (please list): _____

PREVIOUS OPERATIONS: _____

INJURIES: _____

HOSPITALIZATIONS: _____

ALLERGIES: (please check): Tape _____ Penicillin _____ Codeine _____ Iodine _____

Novocain _____ Local Anesthetics _____

Other (please list) _____

LIST MEDICATIONS CURRENTLY TAKEN: _____

Do you smoke? Yes _____ No _____

SMOKER: How many packs per day? _____ How many years? _____

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OUR FINANCIAL POLICY

Thank you for choosing us as your podiatric health care provider. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of Our Financial Policy which we require you to read and sign prior to any treatment. Financial arrangements can be made in one of the following two ways:

CASH

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. We accept cash, check, Mastercard, Visa, and Care Credit.

* Ask about Care Credit for 0% financing options

INSURANCE

As a courtesy to you, we will bill your insurance company for services rendered. **60 days are allowed for processing by the insurance company, any unpaid balance or unpaid claims are your financial responsibility.** For regular office visits and treatments, we require payment of your co-payment and/or unpaid deductibles at the time services are rendered. If you become delinquent, your account(s) are subject to collection procedures.

SUPPLIES

All patients are financially responsible for dispensed supplies.

Signature of Patient/Responsible Party

Date

WELCOME TO KIM FOOT & ANKLE MEDICAL CENTERS, INC.

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Last Name	First Name	Name you like to be called	Age
Home Address		City	State
		Zip	Date of Birth ____/____/____
Email Address	Social Security #	Marital Status	Drivers License #
Home Telephone #	Cell Phone #	Work #	
Spouse's Name	Spouse's Work #		

Responsible Party if Patient is Minor	Relationship	Phone #	Social Security #
Home Address	City	State	Zip
			Drivers License #

Family/Primary Doctor	Phone #	Address
Other Specialist (s)	Phone #	Address

Whom may we contact in case of emergency? _____ Phone # _____

Whom may we thank for referring you to us? _____ Phone # _____

Address _____

I hereby give my permission to Dr. S. Don Kim, Dr. James Jung, Dr. Raymond Bautista, Dr. Steve S. Yoon, Dr. Richard Graves and Associates to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition. I also hereby assign Dr. Kim and Associates all benefits provided by my insurance company policy or policies for medical or surgical care. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature of Insured or Responsible Party

Date

Visit us at: www.kimfoot.com