KANSAS FOOT CARE ASSOCIATES, P.A.
DISEASES & SURGERY OF THE FOOT

MATTHEW R. GALLIANO, D.P.M., F.A.C.F.A.S.
DIPLOMAT, AMERICAN BOARD OF PODIATRIC SURGERY
FELLOW, AMERICAN COLLEGE OF FOOT & ANKLE SURGEONS
SIOBHAN L. GRAY, APRN/NP-C

WELCOME TO OUR OFFICE

*****PLEASE USE BLACK INK ONLY!!*****

Name: (First, Middle, Last, Generation): _____

Name of Parent/Guardian or Payee/Legal Representative: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ **PRIMARY** ☐ Cell Phone: _____ ☐ **PRIMARY**

Social Security Number: _____ **Date of Birth**: _____ Sex: Male or Female

E-mail address: _____

Emergency Contact Name & Phone # _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner ☐ Legally Separated ☐

Employer: _____ Business Phone: _____

Medical Insurance: Primary: _____ Secondary: _____

ID#: _____ ID#: _____

Insured's Name: _____ Date of Birth: _____ Relationship: _____

Primary Language: _____ **Hispanic/Latino Heritage (circle): Yes or No**

Race (circle): American Indian, Alaska Native, Asian, Black, African American, Native Hawaiian, Pacific Islander or White

How did you hear about our office (circle): From a friend*****, Insurance referral, Found us on the Internet Advertisement*****, Patient referral*****, Doctor/Provider referral*****, Yellow Pages, ***please specify**** _____

Are you here as a result of an injury or accident (please check the correct box? Yes ☐ No ☐

We will fill out Workmans Compensation, Social Security Disability or FMLA – Family Medical Leave Act forms for a fee of $25.00 per form. Please allow 10-14 business days to complete this paperwork. This fee is the responsibility of the patient and cannot be billed by us to your insurance company or employer. This fee must be paid when the form is dropped off or before it is mailed or faxed out.

Email is strictly used for relaying information from our office to you, the patient. Email is **NOT** to be used for appointments, advice, prescription request, or any form of treatment.

I certify that my answers are true and complete to the best of my knowledge. I permit Kansas Foot Care Associates, P.A. to leave phone messages both oral and electronic at any of the phone numbers listed above.

Patient Signature: _____ Date: _____