SHADY GROVE PODIATRY
THE FOOT AND ANKLE EXPERTS

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BASIC PATIENT INFORMATION

PATIENT ACCOUNT NUMBER: _____DATE: _____

NAME: _____
LAST *FIRST* *MIDDLE*

BIRTHDATE: _____ AGE: _____ SEX: _____SSN#: _____

ADDRESS:_____APT#:_____

CITY:_____STATE:_____ZIP:_____

PLEASE PROVIDE PHONE NUMBERS AND CHECK OFF WHICH IS YOUR MOST PREFERRED CONTACT:

☐ HOME: _____ ☐ WORK: _____

☐ CELL: _____ ☐ OTHER: _____

OTHER INFORMATION

PRIMARY CARE PHYSICIAN:_____

PCP PHONE#: _____

PHARMACY: _____

PHARMACY LOCATION:_____

PHARMACY PHONE #:_____

E-MAIL ADDRESS: _____

EMPLOYER: _____

PRIMARY LANGUAGE: _____

DO YOU NEED AN INTERPRETER? ☐ YES ☐ NO

IF MINOR, PARENT/GUARDIAN NAME:

_____

DO YOU HAVE AN ADVANCE DIRECTIVE? ("LIVING WILL") ☐ YES ☐ NO

DO YOU GIVE PERMISSION TO ACCESS YOUR PRESCRIPTION HISTORY? ☐ YES ☐ NO

WHICH CATEGORY BEST DESCRIBES YOUR RACE? *(ONE OR MORE CATEGORIES MAY BE MARKED. THIS IS NOT BY ANY MEANS TO DISCRIMINATE AGAINST ANY SINGLE PERSON OR RACE.)*

☐ AMERICAN INDIAN
☐ ALASKA NATIVE
☐ ASIAN
☐ BLACK OR AFRICAN AMERICAN
☐ NATIVE HAWAIIAN
☐ WHITE
☐ HISPANIC
☐ OTHER
☐ UNREPORTED / REFUSE TO REPORT

EMERGENCY CONTACT INFORMATION

NAME: _____ RELATIONSHIP: _____

PHONE#: _____

INSURANCE INFORMATION

PRIMARY INSURANCE:_____ SUBSCRIBER'S NAME: _____

RELATIONSHIP TO PATIENT: _____ POLICY ID: _____ GROUP: _____

SUBSCRIBER'S BIRTHDATE: _____ SOCIAL SECURITY: _____

SUBSCRIBER'S WORK#: _____ SUBSCRIBER'S EMPLOYER: _____

IS PATIENT COVERED BY ADDITIONAL INSURANCE? (IF YES, PLEASE COMPLETE THE FOLLOWING)

SECONDARY INSURANCE:_____ SUBSCRIBER'S NAME: _____

RELATIONSHIP TO PATIENT: _____ POLICY ID: _____ GROUP: _____

SUBSCRIBER'S BIRTHDATE: _____ SOCIAL SECURITY: _____

SUBSCRIBER'S WORK#: _____ SUBSCRIBER'S EMPLOYER: _____

PATIENT HISTORY

WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY?_____

WHEN DID YOUR SYMPTOMS START? _____ WHO REFERRED YOU? _____

WHAT MEDICAL PROBLEMS DO YOU HAVE OR ARE YOU BEING TREATED FOR? PLEASE CHECK ALL THAT APPLY:

☐ ARTHRITIS	☐ DIABETES	☐ CANCER	☐ RESPIRATORY
☐ HEART DISEASE	☐ SEIZURES	☐ ANEMIA	☐ HIV/AIDS
☐ LIVER DISORDER	☐ THYROID PROBLEM	☐ HEPATITIS	☐ STOMACH PROBLEM
☐ KIDNEY DISORDER	☐ NEUROLOGICAL PROBLEM	☐ STROKE	☐ INTESTINAL PROBLEM
☐ HIGH BLOOD PRESSURE	☐ HIGH CHOLESTEROL	☐ SLEEP APNEA	☐ **OTHER:**_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: *(LET US KNOW IF YOU HAVE A LIST TO COPY)*

_____

_____

_____

PLEASE PROVIDE YOUR SURGICAL HISTORY: *(INCLUDE DATES IF POSSIBLE) IE: RIGHT ACL SURGERY – 2007*

_____

_____

_____

PLEASE LIST PAST HOSPITALIZATIONS: *(INCLUDE DATES, REASON IF POSSIBLE) IE: INFECTION – 2009*

_____

_____

_____

PLEASE LIST ANY ALLERGIES TO MEDICATIONS: _____

ARE YOU ALLERGIC TO LATEX? ☐ YES ☐ NO ARE YOU ALLERGIC TO ADHESIVES? ☐ YES ☐ NO

SOCIAL HISTORY

ARE YOU A SMOKER?	☐ YES	☐ NO	IF SO, HOW MUCH DO YOU SMOKE?_____
WERE YOU EVER A SMOKER?	☐ YES	☐ NO	WHEN DID YOU QUIT? _____
DO YOU DRINK ALCOHOL?	☐ YES	☐ NO	HOW OFTEN DO YOU DRINK?_____

FAMILY HISTORY

PLEASE INDICATE WHETHER ANYONE IN YOUR IMMEDIATE FAMILY HAS ANY OF THE FOLLOWING:

☐ ARTHRITIS ☐ DIABETES ☐ HEART DISEASE ☐ CANCER ☐ OTHER: _____

PATIENT CONSENT FOR TREATMENT

I,_____(*PRINT NAME*), CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I GIVE PERMISSION TO DRS. ASSILI, BAEK, SERLO, DANG, AND SADOUGHI TO ADMINISTER AND PERFORM THE PROCEDURES THEY DEEM NECESSARY IN THE DIAGNOSIS AND/OR TREATMENT.

X _____

SIGNATURE OF PATIENT/ PARENT GUARDIAN *DATE*

MEDICARE AUTHORIZATION *(ONLY IF APPLICABLE)*

MEDICARE WILL ONLY PAY FOR SERVICES THAT IT DETERMINES TO BE "REASONABLE AND NECESSARY" UNDER SECTION 1842(A) OF THE MEDICARE LAW. IF MEDICARE DETERMINES THAT A PARTICULAR SERVICE IS NOT REASONABLE AND NECESSARY, PAYMENT WILL BE DENIED. IF MEDICARE SHOULD DENY PAYMENT OF SERVICES RENDERED, I AGREE TO BE PERSONALLY RESPONSIBLE FOR PAYMENT. THIS AGREEMENT IS VALID FOR ALL SERVICES. I AUTHORIZE THE RELEASE OF ANY MEDICAL AND OTHER INFORMATION NECESSARY TO PROCESS THE CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS TO SHADY GROVE PODIATRY, LLC.

X _____

SIGNATURE OF PATIENT/ PARENT GUARDIAN *DATE*

CONSENT AND RELEASE

I CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARD TO MY INSURANCE COVERAGE IS CORRECT AND FURTHER AUTHORIZE THE RELEASE OF ANY NECESSARY INFORMATION, INCLUDING THE INFORMATION FOR THIS OR ANY RELATED CLAIM TO MY STATED INSURANCE COMPANY. EITHER MY INSURANCE COMPANY OR I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING. REGARDLESS OF MY INSURANCE COVERAGE, THERE ARE SOME SERVICES, WHICH ARE NOT COVERED. PAYMENTS FOR THESE NON-COVERED SERVICES ARE MY RESPONSIBILITY AND MUST BE PAID AT THE TIME OF THE VISIT. DURING THE COURSE OF TREATMENT, DURABLE MEDICAL EQUIPMENT MAY BE RECOMMENDED. I AUTHORIZE MY INSURANCE COMPANY TO PAY SHADY GROVE PODIATRY, LLC DIRECTLY. I UNDERSTAND THAT MY INSURANCE WILL COVER THIS ITEM IF IT IS MEDICALLY NECESSARY, BUT THAT I AM RESPONSIBLE FOR ANY NON-COVERED SERVICES, DEDUCTIBLES AND COINSURANCE.

X _____

SIGNATURE OF PATIENT/ PARENT GUARDIAN *DATE*

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I_____ *(PRINT NAME)* ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF SHADY GROVE PODIATRY'S NOTICE OF PRIVACY PRACTICES. THIS NOTICE DESCRIBES HOW SHADY GROVE PODIATRY, LLC MAY USE AND DISCLOSE MY PROTECTED HEALTH INFORMATION, CERTAIN RESTRICTIONS ON THE USE OF AND DISCLOSURE OF MY HEALTHCARE INFORMATION, AND RIGHTS I MAY HAVE REGARDING MY PROTECTED HEALTH INFORMATION. THE FEDERAL GOVERNMENT NOW RESTRICTS SHADY GROVE PODIATRY FROM DISCUSSING MY HEALTH INFORMATION WITH OTHER FAMILY MEMBERS OR PERSONS UNLESS I SPECIFICALLY GIVE WRITTEN PERMISSION. BY MY SIGNATURE BELOW, I GRANT SHADY GROVE PODIATRY PERMISSION TO DISCUSS AND RELEASE MY PROTECTED MEDICAL INFORMATION TO THE FOLLOWING INDIVIDUALS.

NAME: _____RELATION:_____

NAME: _____RELATION:_____

X _____

SIGNATURE OF PATIENT/ PARENT GUARDIAN *DATE*

CANCELLATION POLICY

IN AN EFFORT TO EFFICIENTLY SCHEDULE APPOINTMENTS AND IN CONSIDERATION OF OUR OTHER PATIENTS, WE REQUIRE 24-HOURS' NOTICE IF YOU HAVE TO CANCEL OR CHANGE AN APPOINTMENT. A $50.00 CHARGE WILL OCCUR FOR THE FIRST MISSED APPOINTMENT AND AN ADDITIONAL $25.00 CHARGE WILL OCCUR FOR SUBSEQUENT MISSED APPOINTMENTS. FOR LATE ARRIVALS, WE OFFER A 15 MINUTE GRACE PERIOD FROM THE SCHEDULED TIME. IF YOU ARRIVE LATER THAN THE GRACE PERIOD, YOU WILL BE CHARGED THE FEE.

X _____

SIGNATURE OF PATIENT/ PARENT GUARDIAN *DATE*