Dr. Brian Kashan
Dr. Chanelle Carter,
Board Certified, American Board of Podiatric Surgery

PATIENT INFORMATION UPDATE

Welcome to our office!!!! Please fill this form out completely. If something doesn't apply , just write "NA". Regulations require us to get this information if you haven't been seen for a year.

Name: Birthdate:

Address:

City: State: Zip

Home Phone: Cell Phone: E-Mail:

Emergency Contact: Phone:

Medical Doctor Last Visit

Name of Insurance (Please attach card):

Current Medications:

Current Medical Conditions: Heart Blood Pressure Diabetes Circulation HIV

Breathing Cancer Kidney Liver Ulcers Other:

Allergies:

Do You Use: ☐ Tobacco ☐ Alcohol ☐ Drugs

Current Foot Complaint:

How long have you had this?

Any prior treatment?

Shoe Size: _____ Weight: _____ Height: _____

Have you had a Flu Vaccine _____ Pneumonia Vaccine _____

For Diabetics: Last glucose level____ Last A1C _____

Is your visit today related to any injury on the job or accident? ____Yes ____No

SEE NEXT PAGE

PATIENT UPDATE FORM

INSURANCE AND FINANCIAL DISCLOSURES:

I hereby authorize direct payment of surgical and medical benefits on my behalf to the provider of these services that I would otherwise be payable to me if I did not make this assignment. I understand that I am personally responsible to the physician for charges not covered by my insurance agreement. I also understand that if my account becomes delinquent, I will be responsible for any costs of collection of my account, including collection fees and attorney costs. A $5.00 per month re-invoicing fee may apply to all accounts 60 days past due. I permit a copy of this assignment to be used in place of the original for purposes of billing.

I acknowledge that if my insurance requires a referral, whether it be paper or electronic, that I am responsible for getting an up to date and valid referral. I understand that failure to do so may result in my charges being my responsibility and that payment will be due from me directly.

I understand that I am responsible for providing correct, accurate, and current insurance information at all times. If, as a result of my not providing this information, my claim is denied, I understand that I am responsible for the total amount of my bill to be paid within 30 days of notice, without exception.

The information provided by me is true to the best of my knowledge. I authorize release of any previous medical records by fax, mail or phone by either physician or hospital generated. Also, I herby authorize the doctor or his assistants to initiate the diagnosis and treatment of my condition, to use x-ray examination, or photographs as necessary.

I give Dr. Brian Kashan, D.P.M., P.A. permission to obtain and release medical information to insurance companies and referring physicians. I have read the following and understand and agree to Dr. Brian Kashan, DPM, P.A.'s office policy.

_____

DATE **SIGNATURE OF PATIENT OR LEGAL GUARDIAN**

**If not patient, relationship to patient:
___Parent ___Power of attorney ___Legal Guardian ___ Other: