PLAZA PODIATRY

DR. BRIAN KASHAN, DR. CHANELLE CARTER, D.P.M.
Board Certified, American Board of Foot and Ankle Surgery
410-764-7044 FAX 410-764-8637

WELCOME TO OUR OFFICE!

NEW PATIENT FORM

This form must be filled out completely. Please ask if you need help.

Name:_____Gender _____ M _____ F

Date of Birth:_____Age_____Social Security #:_____

Address: _____City:_____State:___Zip_____

Home Phone #:_____Work Phone#:_____Cell Phone:_____

Marital Status: ____ Single _____Married _____Divorced _____ Widowed _____ Partner _____Legally Separated

Emergency Contact: _____Phone:_____Cell Phone:_____

E-Mail Address:_____ Primary Spoken Language _____

Employment Status ____Full-Time ____Part-Time ____Not Employed

Student Status ____ Full-Time ____Part-Time ____Not a Student

Do you have Advanced Directives (a Will or Living Will) ? ___YES ___NO

Primary Care Physician:_____Referred by:_____

Cardiologist:_____Endocrinologist:_____

Nephrologist:_____Rheumatologist:_____

*****Please describe your foot/ankle problem (include date of injury if applicable) *****

_____

_____

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

How long has the problem been present? _____

Have you had any treatment or taken anything for it? _____

Have you seen someone for this already? __No __Yes Whom?_____

Have you had any prior foot/ankle problems? If yes, please describe: ___No Yes_____

_____

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ALLERGIES

Please check all allergies:

____ Medications:_____

____Foods:_____

____ Tapes or Topical Skin Sensitivity____ Other:_____

What types of reactions have you experienced?

_____

_____

MEDICATIONS

Please list all medications and the dosages: This section MUST be filled out

1._____ 6._____

2._____ 7._____

3._____ 8._____

4._____ 9._____

5._____ 10._____

Personal Medical History:

****Check those that apply to you now or have applied to you in the past****

	Frequent Headache/Migraines		Anemia/Blood Disorders
	Liver Disorder		Pneumonia
	Kidney Disease		Drug/Alcohol Abuse
	Dialysis M W F or T TH SA		Epilepsy or Seizures
	Diabetes Average Blood Sugar _____		Prolonged Bleeding Time
	Asthma		Stomach/Ulcer Disorder
	Emphysema		Thyroid/Parathyroid Disease
	Heart Trouble		High Blood Pressure
	Stroke		Arthritis
	Chest Pain on Mild Exertion		Psychiatric Treatment
	Gout		Emotional Problems/Tension
	BLOOD CLOTS		Asthma/Hay Fever/Shortness of Breath
	Tumor/Abnormal Growth/Cancer		Sexually Transmitted Disease
	Ear, Nose, Throat Disorder		Prostate Disorder
	Hepatitis/HIV		Other

FOR DIABETICS ONLY: Last finger stick reading:_____ Last A1C reading:_____ Date of A1C _____

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SURGICAL HISTORY

Surgical Procedures/Serious Injuries/Illnesses	Year	Physician	Hospital

Has any **family member** had any of the following (please indicate relationship): Indicate M for mother and F for father

Cancer: _____ Diabetes: _____

Heart Trouble: _____ High Blood Pressure: _____

Kidney Disease: _____ Mental or Emotional Disease: _____

Stroke: _____ Tuberculosis: _____

Arthritis: _____ Emphysema: _____

Blood clots: _____ Other:

PATIENT INFORMATION

Do you smoke currently? ____Yes ____No How many packs per day? _____ For how many years? _____

Have you smoked previously? ___Yes ___No When did you quit? _____

Number of caffeine drinks per day? _____ Amount of alcohol consumed per week _____

For women only: Are you pregnant? _____ How many months? _____ Last menstrual cycle_____

Please complete the following:

Height: _____ **Weight:** _____ **Shoe size:** _____ Occupation: _____

Is there any other information you would like us to be aware of: _____No ___Yes

Please describe: _____

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****Please circle off all that *currently* apply to you****

MEDICAL CONDITIONS:

Diabetes High Blood Pressure Heart Disease Heart Murmur Heart Valve Seizures

Asthma Rheumatic Fever Hepatitis Stroke Gout Stomach Ulcers

Anemia Liver Disease Circulation Cancer Infections Nerve Problems

Thyroid Kidney Disease Bleeding Scarring Tuberculosis HIV

Hormones Arthritis Chills Seizures Fever

Muscular/ Skeletal: ___back pain ___joint pain ___joint redness ___joint swelling ___leg cramps ___morning stiffness ___muscle tenderness ___neck pain ___stiffness ___weakness of muscles ___difficulty with walking

Neurological: ___burning in feet tingling in feet or toes ___numbness ___tremors

Psychiatric: ___addictions ___attempted suicide ___depression ___memory loss ___panic attacks

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: _____