

PLAZA PODIATRY
BRIAN KASHAN, D.P.M.
CHANELLE CARTER, D.P.M.
Diplomat, American College of Podiatric Surgery
WELCOME TO OUR OFFICE!

NEW PATIENT INTAKE FORM

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

Race:

American Indian or Alaska Native Native Hawaiian or other Pacific Islander
Black or African American Asian White

Ethnicity:

Hispanic or Latino Not Hispanic or Latino

Primary Care Physician: _____ Referred by: _____

Cardiologist: _____ Endocrinologist: _____

Nephrologist: _____ Rheumatologist: _____

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

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:

- | | |
|----------|-----------|
| 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

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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)

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? _____

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.

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 hereby 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: _____