

**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\*\***

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