SHADY GROVE PODIATRY
THE FOOT AND ANKLE EXPERTS
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BASIC PATIENT INFORMATION

Patient Account Number: _____ **Date**: _____

1. **Name:**_____
   Last *First* *MI*
2. **Birthdate:** _____ **Age**: _____ **Sex**: _____ **SSN#**: _____
3. **Address**:_____**Apt#**:_____

   City:_____ **State**:_____**Zip**:_____
4. **Please provide phone numbers and check off which is your most preferred contact:**

   ☐ Home Number:_____ ☐ Work Number: _____

   ☐ Cell Number: _____ ☐ Other Number: _____
5. **If minor, parent/guardian name**: _____ **Work Phone**: _____
6. **Primary Care Physician**: _____ **Phone#**: _____
7. **Pharmacy**: _____ **Phone#**:_____ **Location:** _____
8. **Do you give permission to access your prescription history?** ☐ Yes ☐ No
9. **Your E-mail address:** _____
10. **Primary Language(s):** _____
11. **Which category best describes your race?** *(One or more categories may be marked. This question is not by any means to discriminate against any single person or race. If you are uncomfortable with specifying then please mark "Unreported / refuse to report.")*

    ☐ American Indian / Alaska Native
    ☐ Asian
    ☐ Black or African American
    ☐ Native Hawaiian
    ☐ White
    ☐ Hispanic
    ☐ Other race
    ☐ Other Pacific Islander
    ☐ Unreported / refuse to report

EMERGENCY CONTACT INFORMATION

Name: _____ **Relationship**: _____

Phone Number: _____

INSURANCE INFORMATION

Primary Insurance:_____ **Subscriber's Name**: _____

Relationship to Patient: _____ **Policy ID:** _____ **Group#:** _____

Subscriber's Birthdate: _____ **Social Security Number**: _____

Subscriber's Work Number: _____ **Subscriber's Employer**: _____

Is patient covered by additional insurance? ☐ Yes ☐ No *(If Yes, please complete the following)*

Secondary Insurance:_____ **Subscriber's Name**: _____

Relationship to Patient: _____ **Policy ID:** _____ **Group#:** _____

Subscriber's Birthdate: _____ **Social Security Number**: _____

Subscriber's Work Number: _____ **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	☐ High Cholesterol
☐ Heart Disease	☐ Seizures	☐ Anemia	☐ High Blood Pressure
☐ Liver Disorders	☐ Thyroid Problems	☐ Hepatitis	☐ Respiratory Problems
☐ Kidney Disorders	☐ Neurological Problems	☐ Stroke	☐ HIV/AIDS
☐ Stomach /Intestinal Problems		☐ Other: _____	

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 all medications you are currently taking: *(let a receptionist know if you have a list to copy)*

_____
_____
_____
_____

Please list any allergies to medications: _____

Are you allergic to LATEX or any 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**, **Lin**, and **Serlo** to administer and perform the procedures they deem necessary in the diagnosis and/or treatment.

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**

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**

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 would appreciate 24-hours notice if you have to cancel an appointment. A $25.00 charge will occur for the first missed appointment and an additional $25.00 charge will occur for subsequent missed appointments.

X_____

Signature of Patient/ Parent Guardian **Date**