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NEW PATIENT PACKET

Basic Patient Information		
Patient Account Number (Office Use Only):	Date:	
Full Name (Last, First, Middle Initial):		
Preferred Name:		
Birthdate:	Age:	
Social Security Number (optional):	Biological sex:	
Street address:		
Provide your phone numbers below and check off which number is primary:		
<input type="checkbox"/> Home:	<input type="checkbox"/> Cell:	<input type="checkbox"/> Work:
Please indicate your preferred methods of receiving appointment reminders:		
<input type="checkbox"/> Phone call at the numbers above	<input type="checkbox"/> Text message to cell number above	<input type="checkbox"/> Email address (indicate below)
Other Patient Information		
Primary Care Physician and location:		
Who referred you to this practice?		
RX Pharmacy and location:		
Employer:		
If the patient is a minor, indicate designated guardian and relation:		
Primary language:		
Email address (write legibly):		
Web-enable for the patient portal using above email?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have an advanced directive (living will)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you give permission to access your RX history?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are you Hispanic or Latino?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Which category best describes you? <i>One or more may be marked, this is not by any means to discriminate against any single person and/or race and will not seter the treatment you receive in our office. This information is collected to ensure that we can provide the highest quality of care for all patients.</i>	<input type="checkbox"/> Asian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Black or African American <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Declined to Specify <input type="checkbox"/> Other (specify): _____	
Emergency Contact Information		
Name of primary emergency contact:		
Relationship of primary emergency contact:		
Phone number of primary emergency contact:		
Name of secondary emergency contact:		
Relationship of secondary emergency contact:		
Phone number of secondary emergency contact:		

Insurance Information			
Primary Insurance:		Secondary Insurance:	
Policy ID#:		Policy ID#:	
Subscriber's name:		Subscriber's name:	
Subscriber's date of birth:		Subscriber's date of birth:	
Subscriber's relationship to patient:		Subscriber's relationship to patient:	
Subscriber's employer:		Subscriber's employer:	
Patient Medical History			
What is the main reason for your visit today?			
Approximately when did your symptoms begin?			
Please check off all applicable conditions to the patient from the lists below:			
<input type="checkbox"/> Diabetes Type 1 / Most recent A1C and date:			
<input type="checkbox"/> Diabetes Type 2 / Most recent A1C and date:			
If you have diabetes type 1 / type 2, who is your endocrinologist?			
<input type="checkbox"/> Anemia	<input type="checkbox"/> Chronic Thrombophlebitis	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Arteriosclerosis Obliterans	<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> HIV / AIDS	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Dermatologic issue	<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Peripheral neuropathy (feet)
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Peripheral vascular disease
<input type="checkbox"/> Blood thinner:	<input type="checkbox"/> Gastrointestinal disease	<input type="checkbox"/> Kidney disorder	<input type="checkbox"/> STI:
<input type="checkbox"/> Buerger's disease	<input type="checkbox"/> GERD / Acid reflux	<input type="checkbox"/> Liver disorder	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Blood thinner:	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Other:
<input type="checkbox"/> Cancer:	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Neurological issue	
<input type="checkbox"/> Cardiovascular disease	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Obesity	
List of your surgical history: <i>IE: 2015 – right ACL surgery</i>			
List of past hospitalizations: <i>IE: 2019 - infection</i>			
Provide the most recent list of medications or list them in the blank space to the right:			
List of allergies to medication: <i>Write NKDA if none.</i>			
Are you allergic to latex?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Are you allergic to adhesives?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Social History			
Are you a smoker?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If so, how much do you smoke?
Were you ever a smoker?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	When did you quit?
Do you drink alcohol?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	How often do you drink?
Family History			
Please check off AND indicate in the spaces below who in your immediate family has or had any of the following:			
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Cancer (what kind)

Patient Consent for Treatment

By signing below, I certify that the above information is true and correct to the best of my knowledge. I give permission to the providers of Shady Grove Podiatry, LLC, Drs. Assili, Baek, Dang, Dillard, Malinsky, and Siegel to administer and perform the procedures they deem necessary upon discussion with me in the diagnosis and / or treatment with my consent.

X _____
Signature of Patient / Parent Guardian Date

Medicare Authorization (Medicare patients only)

Medicare will only pay for services that is determined as "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 by signing below. This agreement is valid for all services submitted to Medicare and subsequently denied including all non-covered Medicare services. I authorize the release of any medical and other information necessary to process the claims submitted. I also request payment of government benefits to Shady Grove Podiatry, LLC.

X _____
Signature of Patient / Parent Guardian Date

Consent and Release

By signing below, I certify that the information I have reported regarding 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 treatment, durable medical equipment may be recommended. I authorize my insurance company to pay Shady Grove Podiatry, LLC directly. I understand that my insurance company will cover this item under the benefit plan if it is medically necessary, but that I am responsible for any non-covered services, deductibles, and co-insurances after insurance processing.

X _____
Signature of Patient / Parent Guardian Date

Receipt of Notice of Privacy Practices Acknowledgement

By signing below, I acknowledge that I have reviewed and / or received upon request the notice of privacy practices of Shady Grove Podiatry, LLC. This notice describes how Shady Grove Podiatry, LLC may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information in accordance with HIPAA and PHI regulations. The federal government now restricts Shady Grove Podiatry, LLC from discussing my health information with other family members or persons unless I specifically give written permission below. By signing below, I grant Shady Grove Podiatry, LLC permission to discuss and release my protected medical information to the following individuals (if you do not wish to list anyone, please sign your name below and leave the first two lines blank).

Authorized individual (full name and relation): _____

Authorized individual (full name and relation): _____

X _____
Signature of Patient / Parent Guardian Date

Cancellation Policy

To efficiently schedule appointments and in consideration of our other patients, we require 24-hours' notice if you must cancel or change an appointment. A \$50.00 charge will occur for the first missed appointment and an additional \$25.00 charge for subsequent missed appointments. We offer a 15-minute grace period from the scheduled appointment time. If you arrive later than the grace period, you will be charged the fee. If there is an emergency, please call us at the earliest opportunity.

X _____
Signature of Patient / Parent Guardian Date

Form Fee Guidelines

Shady Grove Podiatry, LLC charges a fee for the completion of any form which requires medical information and/or a physician's signature. A fee will also apply for the release of medical records (to a patient or requesting party) unless the transmission of the medical records is to be sent to another physician's office. For disability and/or FMLA paperwork, Shady Grove Podiatry, LLC requires at least five (5) business days for completion. If the doctor(s) feels it is necessary to obtain additional information from the patient to complete the form(s), the patient may be required to make an appointment. Payment will be obtained at pick-up of the completed forms. Please further inquire with the front desk as necessary. By signing below, I acknowledge this guideline.

X _____
Signature of Patient / Parent Guardian Date

Deecribe Dictating Service

Shady Grove Podiatry, LLC will be utilizing a HIPAA compliant transcribing dictation service that prepares medical notes by listening (never stored or shared) and allows more time for substantive work for clinicians. By signing below, I, the patient or patient representative, agree and understand the utilization of Deecribe during my appointments at Shady Grove Podiatry, LLC.

X _____
Signature of Patient / Parent Guardian Date