DR. AMIR ASSILI
DR. DAVID BAEK
DR. CHRIS SERLO
DR. HOAN DANG
DR. JON DILLARD

16220 FREDERICK ROAD, SUITE #427
GAITHERSBURG, MD 20877
PHONE: (301) 948-2995 / FAX: (301) 948-6056
EMAIL: CONTACT@SHADYGROVEPODIATRY.COM
WEBSITE: WWW.SHADYGROVEPODIATRY.COM

BASIC PATIENT INFORMATION		
PATIENT ACCOUNT NUMBER (OFFICE USE ONLY):		**DATE:**
NAME (LAST, FIRST, MIDDLE INITIAL):		
BIRTHDATE:		**AGE:**
SOCIAL SECURITY NUMBER:		**GENDER:**
ADDRESS:		**APT / UNIT #:**
CITY:	**STATE:**	**ZIP CODE:**
PLEASE PROVIDE PHONE NUMBERS BELOW AND CHECK OFF WHICH NUMBER IS PRIMARY:		
☐ **HOME#:**	☐ **CELL#:**	☐ **WORK#:**

OTHER PATIENT INFORMATION	
PRIMARY CARE PHYSICIAN:	
PRIMARY CARE PHONE # & LOCATION:	
PHARMACY:	
PHARMACY PHONE # & LOCATION:	
WHAT IS YOUR EMAIL ADDRESS:	
WHO IS YOUR EMPLOYER:	
PRIMARY LANGUAGE:	**DO YOU NEED AN INTERPRETER?** ☐ YES ☐ NO
IF MINOR, PARENT/GUARDIAN NAME / RELATIONSHIP:	
DO YOU HAVE AN ADVANCE DIRECTIVE?	☐ YES ☐ NO
DO YOU GIVE PERMISSION TO ACCESS YOUR PRESCRIPTION HISTORY?	☐ YES ☐ NO
ETHNICITY: ARE YOU HISPANIC OR LATINO?	☐ YES ☐ NO ☐ DECLINED TO SPECIFY
WHICH CATEGORY BEST DESCRIBES YOUR RACE? (ONE OR MORE CATEGORIES MAY BE MARKED. THIS IS NOT BY ANY MEANS TO DISCRIMINATE AGAINST ANY SINGLE PERSON OR RACE AND WILL NOT DETER THE TREATMENT YOU RECEIVE IN OUR OFFICE. THIS INFORMATION IS COLLECTED TO ENSURE THAT WE ARE ABLE TO PROVIDE THE HIGHEST QUALITY OF CARE FOR ALL PATIENTS.)	☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ ASIAN INDIAN ☐ BLACK OR AFRICAN AMERICAN ☐ MIDDLE EASTERN OR NORTH AFRICAN ☐ WHITE ☐ DECLINED TO SPECIFY

EMERGENCY CONTACT INFORMATION	
NAME/RELATIONSHIP:	**PHONE#:**

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
POLICY ID #:	POLICY ID #:
GROUP#:	GROUP#:
SUBSCRIBER'S NAME:	SUBSCRIBER'S NAME:
SUBSCRIBER'S DATE OF BIRTH:	SUBSCRIBER'S DATE OF BIRTH:
SUBSCRIBER'S RELATIONSHIP:	SUBSCRIBER'S RELATIONSHIP:
SUBSCRIBER'S EMPLOYER:	SUBSCRIBER'S EMPLOYER:
SUBSCRIBER'S WORK #:	SUBSCRIBER'S WORK #:

PATIENT MEDICAL 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 BEING TREATED FOR? PLEASE CHECK ALL THAT APPLY:

☐ ARTHRITIS	☐ DIABETES (A1C: ______________)	☐ CANCER	☐ RESPIRATORY
☐ HEART DISEASE	☐ SEIZURES	☐ ANEMIA	☐ HIV/AIDS
☐ LIVER DISORDER	☐ THYROID PROBLEM	☐ HEPATITIS	☐ STOMACH PROBLEM
☐ KIDNEY DISORDER	☐ NEUROLOGICAL PROBLEM	☐ STROKE	☐ INTESTINAL PROBLEM
☐ HIGH BLOOD PRESSURE	☐ HIGH CHOLESTEROL	☐ SLEEP APNEA	☐ DIALYSIS

☐ OTHER: ____

PLEASE LIST ANY ALLERGIES TO MEDICATIONS: ____

ARE YOU ALLERGIC TO LATEX? ☐ YES ☐ NO **ARE YOU ALLERGIC TO ADHESIVES?** ☐ YES ☐ NO

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: (LET US KNOW IF YOU HAVE A LIST TO COPY)	
PLEASE PROVIDE YOUR SURGICAL HISTORY: (INCLUDE DATES IF POSSIBLE) IE: 2007 – RIGHT ACL SURGERY	
PLEASE LIST PAST HOSPITALIZATIONS: (INCLUDE DATES, REASON IF POSSIBLE) IE: 2009 – INFECTION	

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 WHO IN YOUR IMMEDIATE FAMILY HAS ANY OF THE FOLLOWING:

☐ ARTHRITIS	☐ DIABETES	☐ HEART DISEASE	☐ CANCER (WHICH)	☐ 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, SERLO, DANG, AND DILLARD TO ADMINISTER AND PERFORM THE PROCEDURES THEY DEEM NECESSARY IN THE DIAGNOSIS AND/OR TREATMENT WITH MY CONSENT.

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

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

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. IF YOU DO NOT WISH TO LIST ANYONE, PLEASE SIGN YOUR NAME BELOW AND LEAVE THE FIRST TWO LINES BLANK.

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 REQUIRE 24-HOURS' NOTICE IF YOU HAVE TO CANCEL OR CHANGE AN APPOINTMENT. **A $50.00 CHARGE WILL OCCUR FOR THE FIRST MISSED APPOINTMENT AND AN ADDITIONAL $25.00 CHARGE WILL OCCUR FOR SUBSEQUENT MISSED APPOINTMENTS**. FOR LATE ARRIVALS, WE OFFER A 15 MINUTE GRACE PERIOD FROM THE SCHEDULED TIME. IF YOU ARRIVE LATER THAN THE GRACE PERIOD, YOU WILL BE CHARGED THE FEE. IF THERE IS AN EMERGENCY, WE UNDERSTAND AND WOULD APPRECIATE A CALL / NOTIFICATION TO THE OFFICE. THANK YOU.

X ____

SIGNATURE OF PATIENT/ PARENT GUARDIAN DATE