SHADY GROVE PODIATRY
THE FOOT AND ANKLE EXPERTS

16220 FREDERICK ROAD, SUITE #427, GAITHERSBURG, MD 20877
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EMAIL: CONTACT@SHADYGROVEPODIATRY.COM
WEBSITE: WWW.SHADYGROVEPODIATRY.COM

DR. AMIR ASSILI | DR. DAVID BAEK | DR. HOAN DANG | DR. JON DILLARD | DR. COLIN MIZUO

BASIC PATIENT INFORMATION		
PATIENT ACCOUNT NUMBER (OFFICE USE ONLY):		**DATE:**
FULL NAME (LAST, FIRST, MIDDLE INITIAL):		
BIRTHDATE:		**AGE:**
SOCIAL SECURITY NUMBER (NOT REQUIRED):		**GENDER:**
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
PLEASE PROVIDE YOUR PHONE NUMBERS BELOW AND CHECK OFF WHICH NUMBER IS PRIMARY:		
☐ **HOME:**	☐ **CELL:**	☐ **WORK:**

OTHER PATIENT INFORMATION	
PRIMARY CARE PHYSICIAN (FIRST AND LAST NAME):	
PRIMARY CARE PHYSICIAN PHONE # AND LOCATION:	
PHARMACY:	
PHARMACY PHONE # AND LOCATION:	
EMPLOYER:	
IF PATIENT IS A MINOR, INDICATE RESPONSIBLE GUARDIAN:	
EMAIL:	**WEB ENABLE FOR PATIENT PORTAL?** ☐ YES ☐ NO
PRIMARY LANGUAGE:	**DO YOU NEED AN INTERPRETER?** ☐ YES ☐ NO
DO YOU HAVE AN ADVANCE DIRECTIVE (LIVING WILL)?	☐ YES ☐ NO
DO YOU GIVE PERMISSION TO ACCESS YOUR PRESCRIPTION HISTORY TO BEST PROVIDE TREATMENT?	☐ YES ☐ NO
ARE YOU HISPANIC OR LATINO?	☐ YES ☐ NO ☐ DECLINED TO SPECIFY
WHICH CATEGORY TO THE RIGHT BEST DESCRIBES YOU? (ONE OR MORE CATEGORIES MAY BE MARKED. THIS IS NOT BY ANY MEANS TO DISCRIMINATE AGAINST ANY SINGLE PERSON 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 OF EMERGENCY CONTACT:	
RELATIONSHIP OF EMERGENCY CONTACT:	
PHONE NUMBER OF 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 START?			
WHO REFERRED YOU (DOCTOR, FRIEND, FAMILY, SELF)?			
WHAT MEDICAL PROBLEMS DO YOU HAVE OR ARE CURRENTLY BEING TREATED FOR? PLEASE CHECK ALL THAT APPLY:			
☐ DIABETES (A1C: _____)	☐ ARTHRITIS	☐ 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 PROVIDE 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 CHECK OFF AND INDICATE IN THE EMPTY SPACES BELOW WHO IN YOUR IMMEDIATE FAMILY (PARENTS, SIBLINGS, ETC) HAS OR HAD ANY OF THE FOLLOWING:				
☐ ARTHRITIS	☐ DIABETES	☐ HEART DISEASE	☐ CANCER (WHICH)	☐ OTHER:

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, AND MIZUO 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 (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 BY SIGNING BELOW. 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

BY SIGNING BELOW, 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

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND/OR HAVE REVIEWED 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 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, LLC 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, 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 NAME: _____RELATION:_____

AUTHORIZED INDIVIDUAL 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. BY SIGNING BELOW, I AGREE WITH THE ABOVE.

X _____

SIGNATURE OF PATIENT/ PARENT GUARDIAN DATE