Dr. Brian Kashan Dr. Chanelle Carter, Board Certified, American Board of Podiatric Surgery

PATIENT INFORMATION UPDATE

Welcome to our office!!!! Please fill this form out completely. If something doesn't apply , just write "NA". Regulations require us to get this information if you haven't been seen for a year.

Name:			Birthdate:			
Address:						
City:		State:	Zip			
Home Phone:		Cell Phone:		E-Mail:		
Emergency Contact:			Phone:			
Medical Doctor			Last Visit			
Name of Insurance	(Please attach card)):				
Current Medicatior	IS:					
Current Medical Co	onditions: Heart	Blood Pressure	Diabetes	Circulation	HIV	
Breathing C	ancer Kidney	Liver Ulce	ers Oth	er:		
Allergies:						
Do You Use:	□ Tobacco	Alcoho	ol	Drugs		
Current Foot Comp	laint:					
How long have you	had this?					
Any prior treatmen	t?					
Shoe Size:	Weight:	Height	:			
Have you had a	Flu Vaccine Pneumonia Vaccine					
For Diabetics:	Last glucose level Last A1C					
Is your visit today	related to any inju	ury on the job or acc	ident?	Yes	No	

SEE NEXT PAGE

PATIENT UPDATE FORM

INSURANCE AND FINANCIAL DISCLOSURES:

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 herby 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: