

NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU
MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO
THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL
INFORMATION IS IMPORTANT TO US.**

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect **April 14, 2003**, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes. You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Name of Contact Person: Dr. Brian Kashan

Telephone: 410-764-7044 Fax: 410-764-8637

E-mail: drbkas@att.net

Address: 6506 Reisterstown Road Baltimore, MD 21215

**ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was offered/provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Name (please print) Date

Parent or Authorized Representative (if applicable)

Signature

NEXT PAGE PLEASE

**WELCOME TO OUR OFFICE. PLEASE ASK IF YOU NEED HELP WITH THIS FORM
 PATIENT INFORMATION
 (PLEASE PRINT)**

| | | | | |
|-----------------------------|---------------------|--------------|----------------|----------------|
| NAME | | DATE | | |
| ADDRESS | | CITY | STATE | ZIP |
| HOME PHONE | CELL PHONE | SOCIAL SEC # | | |
| DATE OF BIRTH | AGE | SEX M F | MARITAL STATUS | S M W D SEP |
| REFERRED BY | PERSONAL PHYSICIAN | E-MAIL | | |
| PATIENT'S EMPLOYER | BUSINESS PHONE | | | |
| SPOUSE'S NAME | SPOUSE'S WORK PHONE | | | |
| EMERGENCY OR CONTACT PERSON | PHONE | | | |

**PERSON RESPONSIBLE FOR BILL
 (IF OTHER THAN ABOVE)**

| | | |
|----------------------------------|----------------|-----------|
| NAME | RELATIONSHIP | BIRTHDATE |
| ADDRESS (IF OTHER THAN ABOVE) | HOME PHONE | |
| EMPLOYER | BUSINESS PHONE | |

INSURANCE INFORMATION

NAME OF INSURANCE COMPANY

1-

2-

**PLEASE ATTACH ALL INSURANCE CARDS TO THIS FORM FOR US TO COPY
 PLEASE ATTACH ALL REFERRALS TO THIS FORM**

AUTHORIZATIONS

BENEFITS TO PHYSICIAN:

- YES NO I hereby authorize payments directly to the physician of the surgical and/or medical benefits.
- YES NO I also understand I am responsible for any portion of my bill not covered by my insurance company. HMO patients are subject to the coverage benefits of their program.

RELEASE OF INFORMATION

I hereby authorize release of information for insurance claim purposes.

- YES NO The information authorized for release may include information which may be considered communicable or Venereal disease, including hepatitis, syphilis, gonorrhoea, HIV, and AIDS.

I understand all of the above and hereby state that the information is correct to the best of my knowledge.

Date _____

Signed (Insured Person) _____

MEDICAL INFORMATION

This Information Is Important For Our Records And Your Health

Are you allergic to: Penicillin Codeine Sulfa drugs Aspirin Iodine
Novacaine Other: _____

Please list all medications you take regularly:

Please circle any of the following you have or have had a problem with:

Diabetes High Blood Pressure Heart Disease Heart Murmur Heart Valve Seizures
Asthma Rheumatic Fever Hepatitis Stroke Gout Stomach Ulcers
Anemia Liver Disease Circulation Cancer Infections Nerve Problems
Thyroid Kidney Disease Bleeding Scarring Tuberculosis HIV
Hormones Arthritis Other: _____

Have you had any serious illnesses? Please List: _____

Have you had any major surgeries? Please List: _____

Do you have any healing or scarring problems? Please describe: _____

Do you have any artificial joints? Yes No Which ones? _____

Do you have Heart Valve Implants? Yes No

Do you have a pacemaker? Yes No

Family History

Is there a family (blood relative) history of (Please circle all that apply):

Heart disease Arthritis Bleeding Disorder Neurologic Disorder Stroke
Bunions Flat feet Hammertoes Circulation problems in legs or feet
Diabetes Hypertension Other: _____

Social History

Do you smoke? Yes #packs per day _____ No

Previously smoke? Yes #of years _____ No

Do you drink alcohol or beer? Yes How Frequently? _____ No

What is your job description: _____

Employment Activity (Please Check All That Apply): Sitting Standing Walking Retired

Shoe Size _____ Current Weight _____ Height _____

NEXT PAGE PLEASE

PODIATRIC HISTORY

Describe your foot problems: _____

How long has it been bothering you? _____ Days _____ Weeks _____ Months _____ Years

What treatment has been given? _____

Any past problems with your feet and ankles? _____

Any past surgical procedures on your feet or ankles? (Describe) _____

Previous Foot Doctor: _____ Last Visit: _____

Is there any additional information you would like us to know about or would like to tell the doctor privately?

Signature _____ Date: _____

PLEASE LET US KNOW IF YOU HAVE ANY SPECIAL NEEDS.

YOUR REFERRALS OF FRIENDS AND FAMILY ARE GREATLY APPRECIATED!

VISIT US ONLINE AT WWW.PLAZAPODIATRY.COM