David L. Kahan, DPM

Foot & Ankle Specialist

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2 Scripps Drive, Suite 206
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(916) 487-2383

New Patient Checklist

YOU MUST BRING THESE COMPLETED FORMS TO YOUR APPOINTMENT OR WE MAY HAVE TO RESCHEDULE YOUR APPOINTMENT

As a new patient at Dr. Kahan's office this handy guide will prepare you for your appointment and help make the most of your time with the doctor.

Before Your Visit:

- ❑ Make a list of your symptoms and questions.
- ❑ Make a list of **ALL MEDICATIONS AND DOSAGES** and any previous surgeries.
- ❑ Gather and bring important medical records and laboratory test reports from other doctors or hospitals (including X-rays, MRIs, and lab results).
- ❑ Check with your insurance provider to see if a referral is needed.
- ❑ Call before your visit to tell the office if you have special needs.
- ❑ Bring a friend or family member if you think it will be helpful.
- ❑ If your problem involves walking and/or exercise, bring your walking/exercise shoes with you to the appointment.

During Your Visit:

- ❑ Go over your list of questions.
- ❑ If you do not understand an answer, be sure to ask for further explanation.
- ❑ Take notes and listen carefully.
- ❑ Discuss your symptoms and any recent changes you may have noticed.
- ❑ Talk about all new medications.
- ❑ Ask why it has been prescribed, and how to take it.
- ❑ Describe any allergies.
- ❑ Tell your podiatrist if you are pregnant or if you are trying to get pregnant.
- ❑ Let your podiatrist know if you are being treated by other doctors.

After Your Visit:

- ❑ Prepare for any tests your podiatrist orders.
- ❑ Ask about what you need to do to get ready, possible side effects, and when you can expect your results.
- ❑ Ask when and how the test results will be made available to you.
- ❑ Schedule a follow-up appointment (if necessary) before you leave your podiatrist's office.
- ❑ Call or email podiatrist's office and ask for your test results if you do not hear from the office when you are supposed to.

PATIENT REGISTRATION FORMS

PATIENTS NAME: _____DATE OF BIRTH__/____/____
LAST FIRST M.I.

HOME PHONE: ( )_____-_____MBL PHONE: ( )_____-_____Appt. reminder __Call or Text__

HOME ADDRESS:_____
STREET CITY STATE ZIP

Email Address: _____ Social Security #_____

CURRENT PHYSICIAN:_____LAST VISIT: MO: _____ YEAR:_____

REFERRAL SOURCE (INTERNET, FRIEND, MD…)_____

SEX: M F MARITAL STATUS_____ DRIVER'S LICENSE #_____

Height:_____ Weight:_____ Shoe Size:_____ Blood Pressure (if known):_____

Emergency Contact:
Name: _____ Relation:_____ Ph No. _____

IF MINOR PATIENT:
PARENT OR LEGAL GUARDIAN NAME:_____ DOB: _____
MAILING ADDRESS: _____
STREET CITY STATE ZIP

PARENT/LEGAL GUARDIAN SOC SEC #_____

PRIMARY INSURANCE

PLEASE PROVIDE US WITH YOUR INSURANCE CARD(S) FOR OUR RECORDS

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made on my behalf to Dr. David Kahan for any services furnished me by that Physician. I authorize any holder of medical information about me to release to the healthcare financing administration and its agents any information needed to determine these benefits or benefits payable for related services. If other health insurance is indicated in item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agencies shown. In Medicare assigned cases the Physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the Patient is responsible only for the deductible coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

RESPONSIBLE PARTY SIGNATURE:_____ DATE:_____

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for **all** services. I also authorize the physician to release any information required to process an insurance claim. I authorize this signature on all insurance submissions. **I also give my permission to Dr. Kahan to diagnose, administer treatment, and to perform such procedures as may be deemed necessary for my particular foot problems.**

RESPONSIBLE PARTY SIGNATURE:_____ DATE:_____

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FINANCIAL POLICY

WE BILL YOUR INSURANCE AS A COURTESY. PLEASE REMEMBER THAT YOU ARE FINANCIALLY RESPONSIBLE FOR ALL SERVICES. WHILE WE MAKE EVERY EFFORT TO VERIFY YOUR INSURANCE COVERAGE, IT IS THE RESPONSIBILITY OF OUR PATIENTS TO KNOW IN ADVANCE ABOUT THEIR INSURANCE PLANS. WE UNDERSTAND THERE IS A LOT OF CONFUSION WITH ALL OF THE CHANGES IN HEALTH CARE AND INSURANCE'S; HOWEVER, ANY DENIED SERVICES, EXPIRED PLANS OR OTHER CHARGES THAT RESULT IN NON-COVERAGE BY THE STATED PLAN WILL BECOME THE RESPONSIBILITY OF THE PATIENT. DELINQUENT ACCOUNTS WILL BE SUBJECT TO MONTHLY SERVICE CHARGES.

RETURNED CHECK POLICY: All returned checks due to insufficient funds will be subject to a 10% service charge or $25 (whichever is greater) per check. All accounts may be turned over to collections at our discretion.

MEDICARE ONLY: You will be responsible for your Medicare yearly deductible ($183) plus the co-insurance (20%). If your deductible has been met, you will be responsible for 20% of the Medicare allowed charges. We will bill Medicare, and upon receipt of payment or notification from Medicare you will receive a statement showing the balance due. Occasionally, though rarely, Medicare will declare a service as non-covered. In this case the patient will be responsible for these charges.. **IN ORDER TO HELP REDUCE OUR RISING COSTS, MEDICARE CO-INSURANCE PAYMENTS WILL BE DUE AT THE TIME OF SERVICE (BASED ON THE MEDICARE APPROVED FEE SCHEDULE).**

MEDICARE WITH SECONDARY INSURANCE: We will bill both of these carriers as necessary. You will be responsible for any deductibles or other charges not covered by these insurance carriers. You may receive a statement at the beginning of each month. This statement will tell you of all account activity and the status of your account.

PRIVATE INSURANCE ONLY: We will bill this carrier. If it is through an HMO or Managed Care System we require a referral from a primary care physician. The patient is responsible for any co-pay or patient portion designated by the insurance carrier. If you have a deductible, you are responsible for these charges until the deductible is met. You will be required to pay these charges at the time of service. A monthly statement may be sent out at the beginning of each month showing the balance due.

PRIVATE PAY: Non-insured patients must pay the fee at the time of service.

MEDI-CAL ONLY: If you are covered under Medi-Cal or a Geographic Managed Medi-Cal Plan (Blue Cross, Molina) you must bring your eligibility card with you every visit. You must have a written referral from a primary care physician, insurance company, emergency room or diabetes clinic**. Share of cost recipients will be required to pay at the time of service**.

MISSED APPOINTMENTS: All missed appointments will be subject to a $45.00 missed appointment fee. The ONLY exception is that you have called the office 24HRS prior to your appointment to notify us. You will receive a statement within 48 hours of your missed appointment.

INITIALS_____

Health History

Patients Name: _____ DOB: ____/____/_____

History of present illness:
Nature: How can the doctor help you today? _____
Location: Where is the pain/problem? _____
Duration: How long have you had this pain/problem? _____
Onset: Did the pain/problem increase □ gradually? □ suddenly?
Course: Has the pain/problem □ stayed the same? □ getting worse? □ getting better?
Activity: What makes the pain/problem hurt? _____
Treatment: Have you or anyone else treated the problem? _____

Oral contraceptives? □ YES □ NO

PHARMACY NAME and LOCATION? :_____

PAST MEDICAL HISTORY:

AIDS/HIV	Yes No	**Diabetes**	Yes No	Psychiatric Care	Yes No
Anemia	Yes No	Ear Problems	Yes No	Radiation Treatment	Yes No
Angina	Yes No	Epilepsy	Yes No	Respiratory Disease	Yes No
Arthritis	Yes No	Eye Problems	Yes No	**Rheumataic Fever**	Yes No
Artificial Heart valves		Fainting	Yes No	Shortness of Breath	Yes No
Or Joints	Yes No	Foot/leg cramps	Yes No	Sinus Problems	Yes No
Asthma	Yes No	**Gout**	Yes No	Special Diet	Yes No
Back Problem	Yes No	Headaches	Yes No	Stroke	Yes No
Bleeding Disorder	Yes No	Heart Disease	Yes No	Swelling/feet/ankles	Yes No
Cancer	Yes No	Hemophilia	Yes No	Tired Feet	Yes No
Chemical Dependency	Yes No	**Hepatitis/Jaundice**	Yes No	Tuberculosis	Yes No
Chest Pain	Yes No	High Blood Pressure	Yes No	Ulcers	Yes No
Chronic Diarrhea	Yes No	**Kidney Disease**	Yes No	Varicose Veins	Yes No
Circulatory Problems	Yes No	**Liver Disease**	Yes No	Venereal Disease	Yes No
Phlebitis	Yes No	Polio	Yes No	**Work Injuries**	Yes No

Other_____

SURGERIES YOU HAVE HAD:_____

_____

HOSPITALIZATION OTHER THAN SURGERIES LISTED: _____

_____

LIST RELATIONSHIP TO YOU OF FAMILY MEMBERS WHO HAVE HAD:

Diabetes_____ Foot Problems_____ **OCCUPATION: _____**
Arthritis_____ Heart Attack_____
Stroke_____ High Blood Pressure_____ **HOBBIES:_____**
Cancer_____ Birth Defects_____

# of Childbirths____ Are you currently pregnant? Yes No
Are you slow to heal after cuts? Yes No
Any abnormal bruising, bleeding or scarring? Yes No

Do you smoke now? Yes No Packs/day____ Years____
Did you ever smoke? Yes No Packs/day____ Years____
If you quit smoking,when did you do so?_____
Alcoholic beverages? (circle one) None Rarely Moderately Quit
Recreational Drugs? (circle one) None Rarely Moderately Quit

INITIALS _____

MEDICATION AND ALLERGY FORM

Patient Name _____ DOB: _____/_____/_____

CURRENT MEDICATIONS: PLEASE INDICATE DOSAGE AND HOW MANY 1, 2 , 3 PER DAY?

EXAMPLE: IF TAKING1 PILL DAILY PUT 1NEXT TO MEDICATION

□ No Medications □ Medication List Attached

BLOOD PRESSURE

□ Tenormin ____mg _____day
□ Cozaar ____mg _____ day
□ Cardizem (Diltiazem) ____mg _____day
□ Plendil (Felodipine) ____mg _____PER DAY
□ Prinivil Zestril (Lisinprol) ____mg _____day
□ Lopressor/ Toprol (Metoprolol) ____mg _____day
□ Aldactone (Spironolactone) ____mg _____day

DIABETIC

□ Glucophage (Metformin) ____mg _____day
□ Glucotrol (Glipizide) ____mg _____day
□ Humalog
□ Micronase (Glyburide) ____mg _____day
□ Lantus
□ Novolog □ Byette

DIURETICS

□ Hydrochlorothiazide(HCTZ) ____mg _____day
□ Zaroxolyn (Metolazone) ____mg _____day
□ Lasix(Furosemide)____mg _____day

THYROID

□ Synthroid (Levothyroxine)

CHOLESTEROL

□ Crestor ____mg _____day □ Lipitor (Atorvastatin) ____mg _____day □ Mevacor (Lovastati) ____mg _____day
□ Vytorin ____mg _____day □ Zocor ____mg _____day

PAIN

□ Advil, Motrin (Ibuprofen) ____mg _____day
□ Aspirin ____mg _____day
□ Celebrex ____mg _____day
□ Naprosyn ____mg _____day
□ Norco (Hydrocodone/Acet) ____mg _____day
□ Ultram (Tramadol) ____mg _____day
□ Vicodin (Hydrocodone) ____mg _____day

STOMACH ACID

□ Nexium ____mg _____day
□ Prevacid (Lansoprazole) ____mg _____day
□ Prilosec (Omeprazole) ____mg _____day
□ Protonix (Pantoprazole) ____mg _____day

Other Medication Not Listed:_____

_____

ALLERGIES: CHECK THE MEDICATION YOU ARE ALLERGIC TO & WRITE IN ANY THAT ARE LISTED

□NO ALLLERGIES

ALLERGIES TO MEDICATIONS

□Advil □Penicillin □ Codeine
□ Sulfa/Bactrim □ Erythromycin □ Vicodin/(Hydrocodone)

NON MEDICATION ALLERGIES:

□ Latex □ _____
□ _____ □ _____

ANY Allergies Not Listed: _____

_____

_____
STAFF INITIALS

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ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices from Dr. Kahan and that I have read (or had the opportunity to read if I chose) and understand the notice.

_____ _____

Patient Name (print please) **Date**

_____

Patient or Authorized Representative (if applicable)

_____

Signature

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RECORDS RELEASE

DATE: _____

I hereby authorize: Dr. _____

Institution Name: _____

Address: _____

_____

Phone#: _____FAX: _____

to release my records and all information including the diagnosis and records of any treatment or exam rendered to me

□ **Records for most current office visit, including labs and X-ray reports**
□ **All Medical Records**
□ **OTHER: _____**

Send or Fax records to:

Dr. David L. Kahan, DPM
2 Scripps Dr., Suite 206
Sacramento, CA 95825
(916) 487-2383
(916) 487-0772 FAX

Patient Name: _____ Date of Birth: ___/_____/_____

Patient Signature: _____
(Signature of parent or guardian if patient is a minor)

A PHOTOCOPY OF THIS DOCUMENT SHALL BE VALID AS THE ORIGINAL