PATIENT REGISTRATION

(Please Print)

Date_____/_____/_____

PATIENT INFORMATION:

Patient Name_____ Sex: M____F____
First Last Middle

Home Address_____ Apt#_____

City_____ St_____ Zip_____ Home Phone _____

Single ___Married ___Widowed ___Separated ___Divorced ___ Cell Phone _____

Date of birth_____/_____/_____ Age_____ Height _____ Weight _____  Size _____

Race: Am. Indian ___Asian ___Black ___Caucasian ___Pacific Islander ___Other Race ___Decline to Answer___

Ethnicity: Hispanic ___Non-Hispanic ___Decline to Answer___ ***Primary Language:*** _____

E-mail Address: _____

Employer _____ Social Security # _____

Occupation _____ Work Phone _____

In case of Emergency Contact _____Phone _____

Whom may we thank for referring you to this office _____

Which Dr. referred you to our office: _____

INSURANCE #1

Member Name _____ Date of birth _____/_____/_____

Social Security # _____ Relationship to Patient _____

Employer_____ Insurance Company_____

INSURANCE #2

Member Name _____ Date of birth _____/_____/_____

Social Security # _____ Relationship to Patient _____

Employer_____ Insurance Company_____

Patient's or authorized person's signature. I authorize the release of any medical or other information necessary to process this claim. I also request payment of medial or government benefits to the undersigned Physician or Supplier for services.

Signature _____ Date_____/_____/_____

PATIENT REGISTRATION

(Please Print)

PATIENT'S HEALTH HISTORY:

Foot Symptoms _____

_____

_____ When did symptoms begin _____

Family Doctor _____ Last Visit _____

Podiatrist _____ Last Visit _____

Pharmacy Name: _____

Pharmacy Address or phone number: _____
(For Address you may use the cross streets and zip code)

Check any illness or condition you have or have had:

DIABETES____ STROKE ____ EPILEPSY____ HEART DISEASE ____ ASTHMA____GALL BLADDER_____

RHEUMATIC FEVER_____ CANCER_____ AIDS____ METAL IN BODY _____ CLAUSTROPHOBIA _____

ARTIFICIAL JOINT/IMPLANT____HIGH BLOOD PRESSURE_____ KIDNEY_____ DIALYSIS_____

STOMACH PROBLEMS____ (G. I. Problems, Ulcers) Do you need an antibiotic before surgery Y____N____

Other Medical Conditions Not Listed Above: _____

_____

_____

Are you Pregnant Y_____ N_____ If you have recently given birth are you nursing? Y_____ N _____

PREVIOUS SURGERIES _____

_____

_____

MEDICATIONS AND VITAMINS TAKING: _____

_____

_____

Are you **ALLERGIC** to any medications: No____ Yes____ Please list_____

_____

_____

Do you use **TOBACCO** products: No ___Yes___ DAILY Amount _____

Do you drink **ALCOHOLIC** beverages: No ___Yes___ DAILY Amount _____

I certify that the above information is correct and best of my knowledge.

Signature_____ Date_____/_____/_____

Pre-Existing Inquiry

PATIENT: _____

Your Insurance Plan may have a pre-existing clause that states that any treatment you had for a medical condition prior to obtaining coverage with them will not be covered for that condition. Please fill out the questions, below.

Prior to _____, have you been treated by any other physician for your current medical condition.

Yes No

If yes, when and by whom were you treated.

_____

_____

_____ _____

Signed Date

Clausula de condición médica que pre-exista

Su seguro medico puede tener una clausula en respecto a condiciones que pre-existan. Si usted ha recibido tratamiento para su enfermedad antes de obtener cobertura con ellos, su tratamiento no será cubierto por esa enfermedad. Por favor llene las preguntas siguientes.

Antes de _____, ha sido usted tratado por otro médico por su enfermedad presente.

Si No

Si contesto Si, con quien y cuando recibió tratamiento?

_____

_____

_____ _____

Firma Fecha

Other Insurance Inquiry

Patient: _____

Are **you** covered by another health plan besides _____
Primary Insurance Name

Yes No

If yes, you will need to provide our office with a copy of your card.

Name of Insurance Company: _____

Address: _____

Name of insured person: _____ Date of Birth: _____

Policy Number: _____ Effective Date: _____

Termination Date: _____ (if applicable)

_____ _____
Patient Signature Date

Encuesta de Otro Seguro Medico

Tiene **usted** otro plan de seguro medico aparte de _____
Nombre de aseguranza que es primaria

Si No

Si contesto “Si”, usted tiene que proporcionar nuestra oficina con una copia de la tarjeta.

Nombre del seguro medico _____

Direccion_____

Nombre de la persona asegurada _____ Fecha de nacimiento _____

Numero de póliza_____ Fecha de empiezo _____

Fecha de terminación_____ (Si es aplicable)

_____ _____
Firma del Paciente Fecha

WELCOME TO OUR OFFICE

Welcome to our office. To allow us to serve you better it is important to follow up with your appointment and medical treatments. We will be glad to assist you with your scheduling.

Missing appointments affects your care. Should you miss or cancel 3 treatments, we will regrettably be unable to continue your care. We will provide emergency care for 30 days. We will provide you a list of Doctors in Las Vegas and send a copy of your records to the Doctor you request.

Thank you for your cooperation.

_____ _____/_____/_____

Signature Date

BIENVENIDOS A NUESTRA OFICINA

Bienvenidos a nuestra oficina. Para permitirnos que le sirvamos mejor es importante que usted venga a sus citas y sus tratamientos que el Doctor le ordene. Estamos disponibles en asistirlo en hacer sus citas.

A no asistir a sus citas afecta su tratamiento. Si usted cancela o falta 3 tratamientos, lamentablemente no podemos seguir su cuidado. Nosotros le proveeremos cuidado de emergencia por 30 días. Le haremos disponible una lista de Doctores en Las Vegas y enviaremos copias de su expediente al Doctor que usted escoja.

Gracias por su cooperación.

_____ _____/_____/_____

Firma Fecha

NEVADA FOOT
4631 E. Charleston Blvd
Las Vegas, NV 89104

HIPPA COMPLIANCE PATIENT CONSENT FORM

We are required by law to maintain the privacy of and provide individuals with the notice of our legal duties and privacy practices with respect to protected health information.

I understand that as part of my health care, **Nevada Foot**, originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test results, diagnoses, treatment, and future care or treatment. I understand that this information serves as basis for planning my care and treatment, as means of communication to those who contribute to my care, a source of information for applying diagnosis, and a means by which a third party payer can verify that services billed were actually provided.

I consent for **Nevada Foot** to request, release, or discuss my health information or records with other health professionals such as primary physicians, referring consults, labs, physical therapy, pharmacists, and other health professionals relating to my care.

I understand **Nevada Foot** will maintain then shred my medical records after five (5) years or longer if required by statue.

I understand that I do have the right to restriction to the use or disclosure of my health information, but **Nevada Foot** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treatment as permitted by Section 164.506 of the Code of Federal Regulations.

I give the following persons access to the use or disclosure of my health information.

Individual:_____ Relationship: _____

Individual:_____ Relationship: _____

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted used including disclosures via fax.

Signature below is only acknowledgment that I have carefully read a copy of the Notice of Privacy Policies for **Nevada Foot**.

Signed: _____ Date: _____/_____/_____

Print Name: _____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____

Witnessed by:_____

FMLA/ Work/ Disability Form Policy

Initials

Our office will be glad to provide you our **standard** note for time out of work/school at no charge at the end of your visit. _____

We will fill out your Culinary *Loss of Time*, Culinary *Extended Eligibility,* or Culinary *Disability* at no charge the Thursday after our office receives your forms. _____

If you have any **special forms,** such as FMLA, special disability, special out of work, etc., that need be to filled out; there will be a $75.00 fee for all the forms brought in at the *same* time. **Payment is due before your forms are filled out.** _____

Any changes or additional forms will have a $75.00 fee per form paid. The fee must be paid in advance. (Hint: An earlier release is easier and less expensive than extending time off.) _____

All forms must be received by our office on ***Wednesday no later than 4:00 pm.*** Any forms received after the deadline will not be ready until Friday of the following week. _____

It is your responsibility to make sure we have the correct dates you will be out of work. _____

If you want your forms filled out immediately, there is a $125.00 fee per form. The fee must be paid in advance. Your form(s) will be ready for pick-up that same day at 4:00pm. _____

If your forms are faxed, you must pay the fee before we fill out the forms. _____

It is your responsibility to make sure we receive all forms sent by your employer/ disability insurance. Make sure the person faxing the forms includes your name and date of birth. We will *not* notify you if forms are faxed in. _____

Forms will be ready for pick-up on Friday after 8:00 am at 4631 E. Charleston, unless special arrangements have been made with our office. _____

We do not fax forms anywhere. _____

I have read and understand the FMLA/Work/Disability Form Policy.

_____ _____

Patient Signature Date

Financial Disclaimer

As a courtesy, our office will verify your medical benefits & file your insurance claims after treatment. Ultimately it is your responsibility to call your insurance company and verify coverage, follow up on ANY and ALL outstanding claims, to know your plan & know remaining available benefits.

All charges incurred are your responsibility regardless of insurance coverage, estimates given by our office, benefits which were verified by our office, or status of claims.

Your office visit copayment includes your examination and written prescriptions, if necessary.

_____
Initial

X-rays, injections, orthotics, taping, and any other procedures will be additional services and fall under separate benefits. Please ask if you have any questions.

_____
Initial

I understand that I am responsible for any amounts not covered by my insurance.

_____ _____

Signature Date

Illness/ Injury Details
Detalles de Enfermedad/ Accidente

Please answer the following questions:

Is treatment today for an accident related injury: ☐ Yes ☐ No

1. WHEN did the illness or injury occur? _____
2. WHERE did the illness or injury occur? _____
3. HOW did the illness or injury occur? _____
4. Do you believe that your illness or injury was work related? ☐ Yes ☐ No
   If this is work related, did you report the condition to anyone?
   ☐ Yes ☐ No
   If yes, to whom? _____ Date: _____
5. Do you expect to receive or have you been provided with Workers Compensation Benefits?
   Yes ☐ No ☐

(Note: Worker's Compensation is not the same of State Disability)

IF THIS VISIT IS RELATED TO AN INJURY CAUSED AT WORK, YOU WILL BE RESPONSIBLE FOR THIS BILL, IF IT HAS NOT BEEN APPROVED BY YOUR CLAIM ADJUSTOR.

Por favor responda a las siguientes preguntas:

¿Su consulta de hoy, está relacionada a un accidente? ☐ Si ☐ No

1. ¿CUANDO ocurrió la enfermedad o accidente?_____
2. ¿DONDE ocurrió la enfermedad o accidente? _____
3. ¿COMO ocurrió la enfermedad o accidente? _____
4. ¿Usted cree que su enfermedad o accidente está relacionado con el trabajo?
   ☐ Si ☐ No
   ¿Si está relacionada con su trabajo, usted le reporto su condición a alguien?
   ☐ Si ☐ No
   ¿A quién se lo reporto? _____ Fecha _____
5. ¿Usted espera recibir o ha recibido beneficios de compensación del trabajador?

(Nota: Compensación del trabajador no es igual que la Incapacidad Estatal)

SI SU VISITA HOY ESTA RELACIONADO CON UN ACCIDENTE DE TRABAJO, USTED SERA RESPONSIBLE POR LA VISITA DE HOY AL MENOS QUE SU AJUSTADOR APROBO LA VISITA

_____ _____
Patient Name (Nombre de paciente) Patient Signature (Firma del paciente)

_____ _____
Insured Name (Nombre de miembro) Date (Fecha)