MINOR PATIENT REGISTRATION
(Please Print)

Date____/____/____

PATIENT INFORMATION:

Patient Name_____Sex:M☐ F☐
First Last Middle

Home Address_____Apt#_____

City_____ St_____ Zip_____ Home Phone(__)____-_____

Date of birth____/____/____ Age_____ Height _____ Weight _____  Size _____

Social Security # _____ E-mail Address:_____

Parent or Legal Guardian Name: _____ Cell Phone (___)__-_____

In case of Emergency Contact _____Phone (___)_____-_____

Whom may we thank for referring you to this office_____

INSURANCE # 1:

Member Name _____ Date of birth ____/_____/____

Sex: M☐ F☐ Relationship to Patient:_____

Social Security # _____ Employer_____

Occupation_____ Insurance Company_____

INSURANCE # 2:

Member Name _____ Date of birth ____/_____/____

Sex: M☐ F☐ Relationship to Patient:_____

Social Security # _____ Employer_____

Occupation_____ 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.

Parent/Guardian Signature_____ Date____/____/____

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PATIENT'S HEALTH HISTORY:

Foot Symptoms _____

_____

_____ _____When did symptoms begin _____

Family Doctor _____ Last Visit _____

Podiatrist _____ Last Visit _____

Check any illness or condition you 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)

Other Medical Conditions Not Listed Above:_____

_____

_____

Are you Pregnant Y☐ N☐ If you have recently given birth are you nursing? Y☐ N ☐

Do you need an antibiotic before surgery 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.

Parent/Guardian 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 condicion medica que pre-exista

Su seguro medico puede tener una clausula en respecto a condiciones que pre-existan. Si usted ha recibido tratmiento para su enfermedad antes de obtener covertura con ellos, su tratmeinto no sera cuvierto por esa enfermedad. Porfavor llene las preguntas siguentes.

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

Si No

Si contesto Si, con quien y cuando recibio 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

Inquesta 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 porporcionar nuestra oficina con una copia de la tarjeta.

Nombre del seguro medico _____

Direccion_____

Nombre de la person asegurada _____ Fecha de nacimiento _____

Numero de poliza_____Fecha de empiezo _____

Fecha de terminacion_____(Si es applicable)

_____ _____
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 assistirlo en hacer sus citas.

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

Gracias por su cooperacion.

_____ _____/_____/_____

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 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:_____