LAS VEGAS FOOT AND ANKLE CENTER

2649 W. HORIZON RIDGE PARKWAY SUITE 100
HENDERSON, NV 89052
(702) 565-6641

MEDICAL HISTORY FORM – (This form is CONFIDENTIAL)

PLEASE PRINT CLEARLY (Return to the Front Desk when both sides are completed)

NAME ______________________ **Date** ______________

Date of Birth ______________ Age ________ Occupation ______________________

Current Height:______________ Weight:______________ Shoe Size:______________

Preferred Language:______________________ Ethnicity & Race ______________________:

Name of Primary Care Physician/ Referring Physician: ______________________ Phone # ______________

Last Visit with Physician:______________ Has he/she requested you be seen in our office? Yes No

What is your **FOOT** or **ANKLE** problem? PLEASE BE SPECIFIC. Where does it hurt? How long has it been bothering you? Is the pain sharp, dull, deep or superficial, stabbing or burning? Does it ache or tingle? Is there any numbness? Have you had any previous treatment(s)?

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LIST CURRENT MEDICATIONS – List dosage and why you are taking each medication. Attach a separate list if necessary.

Pharmacy Name______________________ **Phone#**______________________

1)______________________ **4)**______________________.
2)______________________ **5)**______________________.
3)______________________ **6)**______________________.

ALLERGIES: Penicillin ______ Sulfa ______ Codeine ______ Other ______________________

LIST PREVIOUS SURGERIES OR HOSPITALIZATIONS

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PATIENTS HISTORY – Do you have any of the following?

Heart Disease ______ Diabetes ______ Kidney Disease ______ Liver Disease ______ Lung Disease ______ High Blood Pressure ______
Thyroid Disease ______ Cancer type ______ other medical problems ______________________

WHO IN YOUR FAMILY HAS?

Heart Disease? ______________ High Blood Pressure? ______________ Cancer? ______________
Stroke? ______________ Other Family Related Medical Problems ______________

HAVE YOU EVER SMOKED?	**YES**	**NO**	**when did you quit?** ______________	
DO YOU SMOKE NOW?	**YES**	**NO**	**How many packs a day?** ______________	**For how many years?** ________
DO YOU DRINK ALCOHOL?	**YES**	**NO**	**How much a day?** ______________	**A week?** ______________

CIRCLE ALL THAT APPLY

Constitution: Good general health; recent weight change, Fever, Fatigue.

Eyes: Eye disease or injury, Blurred vision, Double vision, Glaucoma. Wear glasses/ Contacts.

Ears, Nose, Mouth, and Throat: Hearing loss, Tinnitus, Ear aches. Sinus problems, Nose bleeds, Mouth sores, Bleeding gums, Sore throat, Voice change, swollen neck glands.

Cardiovascular: High Blood Pressure, Heart Disease, Heart attack, Chest pain, Angina, Palpitations.

Respiratory: Coughs, Lung Disease, Spitting up blood, Shortness of breath, Asthma.

Gastrointestinal: Loss of appetite or change in bowel movements, Nausea, Vomiting, Diarrhea, History of rectal bleeding, Abdominal pain, Heartburn, History of stomach ulcer.

Musculoskeletal: Joint pain, Stiffness, Muscle weakness, Muscle cramps, Back pain, Difficulty with walking.

Integument/Skin: Rash, Itching, Change in skin color, Change in nails.

Neurological: Frequent / Recurring headaches, light headedness, dizziness, Convulsions, Seizures, Numbness, Tingling sensations, Tremors, Paralysis, Stroke, Head injury.

Psychiatric: Memory loss, Nervousness, Depression, Insomnia.

Endocrine: Glandular problems, Hormone problems, thyroid disease, **DIABETES,** Heat intolerance, Cold intolerance.

Hematologic/Lymphatic: Slow to heal after cuts, bleeding tendencies, Anemia, Phlebitis, Past transfusions, enlarged glands.

Immunological: Hepatitis A _____ B _______ C_____ , HIV, and Tuberculosis.

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PLEASE PRINT CLEARLY AND FILL OUT COMPLETELY

Patient Information

First Name:______________ Last: ______________ MI:________

Email Address: ______________

Patient's Street Address: ______________

City:______________ State: ______________ Zip: ________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Please check primary number where you can be reached at for medical reasons: ☐ Home Phone ☐ Cell Phone ☐ Business Phone

Date of Birth: ________ Social Security #: ______________ Marital Status: ________ Gender: M F

Employer: ______________ Employer Phone: ______________

Employer Address: ______________

City: ______________ State: ______________ Zip: ________

PRIMARY INSURANCE INFORMATION

Responsible Party First Name: ______________ Last: ______________ MI:________

Social Security #: ______________ Date of Birth: ______________ Employer: ______________

Insurance Company: ______________

Policy Number: ______________ Group Number: ______________

Insured relationship to patient: ______________ Insurance Co-payments $ ______________

SECONDARY INSURANCE INFORMATION

Responsible Party First Name: ______________ Last: ______________ MI:________

Social Security #: ______________ Date of Birth: ______________ Employer: ________

Insurance Company: ______________

Policy Number: ______________ Group Number: ______________

Insured relationship to patient: ______________ Insurance Co-payments $ ______________

GUARANTOR INFORMATION – IF SAME AS PATIENT, DO NOT COMPLETE.

First Name: ______________ Last: ______________ MI:________

Address: ______________ City: ______________ State: ________ Zip: ________

Home Phone: ______________ Work Phone: ______________ Date of Birth:______________

Social Security #: ______________ Employer: ______________ Relationship to Patient: ________

Was this an accident? ☐ Yes ☐ No Is this a workers compensation claim? ☐ Yes ☐ No

Name of you Emergency Contact person not living with you: ______________

Phone: ______________ Relationship to patient: ______________

CONTINUED ON REVERSE SIDE

FINANCIAL RESPONSIBILITY POLICY

I hereby give permission for Las Vegas Foot & Ankle Center to examine and render medical and / or surgical treatment. I also agree to follow ALL prescribed treatment. I authorize photographs to be taken for medical education purposes. I also authorize the release of any information required in the course of examination or treatment. Las Vegas Foot & Ankle Center agrees to provide podiatric medical services for the patient whose name appears below.

It is customary to pay for professional services when rendered. Therefore, all are due at the time treatment is provided. As a courtesy, our office will bill your primary insurance for you. A finance charge of 1.5% per month (18% per annum) will be charged on outstanding balances of 90 days (minimum service charge $1.00). At 90 days, if the undersigned fails to pay the FULL AMOUNT for goods or services rendered, a reasonable collection fee will be assessed and the account will be turned over to a collection agency. There will also be a $35.00 charge (to you personally, not your insurance provider) if you miss an appointment and fail to notify our office 24 hours prior to your appointment. The undersigned agrees to pay **ALL** court costs and **ALL** attorney fees involved in recovering any outstanding balance due on this account.

Insurance may pay all or part of your financial obligation to Las Vegas Foot and Ankle Center. However, you are responsible to see that all accounts are completely paid within 90 days. It is very important for you to understand that it is impossible for our office to know what your particular insurance plan will cover, what it will allow, or what it will pay for services we render to you. Many times we won't know this information until after we receive the Explanation of Benefits (EOB) from your insurance company. Therefore, by becoming a patient of Las Vegas Foot & Ankle Center YOU assume complete and total responsibility for all charges.

I understand and accept financial responsibility for payment of all accounts with Las Vegas Foot & Ankle Center.

Signature of patient or responsible party______________________________

Patient's name (Printed) ______________________________ **Date** ______________

IF PATIENT IS UNDER 18 YEARS OF AGE: I hereby authorize treatment for the minor whose name appears above as "patient".

Signature of patient or responsible party ______________________________

Relationship ______________________________ **Date** ______________

PLEASE GIVE INSURANCE CARDS AND A PHOTO I.D. TO RECEPTIONIST WHEN YOU COMPLETE THIS FORM.

OFFICE POLICY FOR LAS VEGAS FOOT & ANKLE CENTER

Thank you for choosing Las Vegas Foot & Ankle Center. In Order to expedite your visit and to ensure that we are accessible to all of our patients, we have put together some guidelines for you.

Cancellation Policy: We require **24 hour notice** for all cancelled appointments. Naturally there will be unexpected circumstances where this would be overlooked such as a family emergency, but we would like to keep our schedules efficient.

Disability Forms: We are happy to complete any paperwork for our patient's; however there is a fee for this and we should receive this up front. We would like at least **3 days** to complete them.

Fees are incurred for the following services:

Missed appointments	$35.00
Copy of X-Rays(Digital)	$25.00
Short term disability forms	$30.00
Long term disability forms	$30.00
Letters after 4-6 week post-op appts	$30.00
Copy of Medical Records Per Page	$ .60

IMPORTANT NOTICE: None of these fees are billable to your insurance company. They are not considered covered services by any insurance company.

Please Initial________

Notice of Privacy Practices for Health Information
Acknowledgement Form

The law require that Las Vegas Foot & Ankle Center must provide to the patient a copy of our Notice of Privacy Practices for Health information. By Signing below, the patient acknowledges receipt of such, or if you are the patient's legal representative or authorized agent, you acknowledge receipt of such.

Signature of patient or responsible party______________________________

Patient's name (Printed)______________________ **Date.**____________

Please indicate who we are allowed to release any information to other than yourself

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I have attempted to provide the patient a copy of our NPP, but was unable to do so for the following reasons:______________________________

____

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Signature of Doctor's representative____________________ **Date**__________

Print Name________________________

LAS VEGAS FOOT & ANKLE CENTER
NOTICE OF PRIVACY PRACTICES

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

INFORMATION. **PLEASE**

REVIEW CAREFULLY.

LAS VEGAS FOOT & ANKLE CENTERS LEGAL DUTY

LAS VEGAS FOOT & ANKLE CENTER is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

LAS VEGAS FOOT & ANKLE CENTER uses your personal health information primarily for treatment; obtaining pavment for treatment; conducting internal administrative activities, and evaluatmg the quality of care we provide. For example; LAS VEGAS FOOT & ANKLE CENTER may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives, or other health related benefits that could be of interest to you.

LAS VEGAS FOOT & ANKLE CENTER may use or disclose your personal health information without prior authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

For any other situation, LAS VEGAS FOOT & ANKLE CENTER'S policy is to obtain your written authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

LAS VEGAS FOOT & ANKLE CENTER may change its policy at any time. When changes are made; a new Notice of Privacy of Practices will be posted in the waiting room and patient exam areas; and will be posted; and will be provided on your next visit. You may also request an updated copy of our Notice of Privacy of Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law or in an emergency circumstances. LAS VEGAS FOOT & ANKLE CENTER will consider all such requests on a case by case basis, but is not legally required to accept them.