



# MINOR 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 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.

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

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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

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## 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 statute.

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 provide you a note for time out of work/school free of charge at the end of your visit.

\_\_\_\_\_

If you have any additional forms that need be to filled out there will be a \$25.00 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 \$25.00 fee per form paid. The fee must be paid 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 \$50.00 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 employer or disability insurance faxes the forms, 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

**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)