

# DESERT FOOT & ANKLE

JOHN D. UTLEY, DPM

Established patient     New patient     Pregnant

DATE: \_\_\_\_\_ PATIENT NAME: \_\_\_\_\_  M  F

BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_ EMAIL: \_\_\_\_\_ RACE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT. \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ --

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ HOME PHONE #: (\_\_\_\_\_) \_\_\_\_\_ CELL#: (\_\_\_\_) \_\_\_\_\_

We require every patient's SSN in order to ensure payment for our services. If you are not willing to provide us with your SSN you have the option of paying for services up front at the time of your visit.

EMPLOYER \_\_\_\_\_ OCCUPATION: \_\_\_\_\_ WORK # (\_\_\_\_) \_\_\_\_\_

PATIENT STATUS:     Child under 18     Single     Married     Divorced     Separated     Widowed

### Emergency Contact:

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

REFERRED BY:     Doctor \_\_\_\_\_     Friend/Family \_\_\_\_\_     Online     Website     Ins book

### Insurance Information:

**PRIMARY INSURANCE CO.** \_\_\_\_\_

POLICY or ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

INSURED'S NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

**SECONDARY INSURANCE CO.** \_\_\_\_\_

POLICY or ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

INSURED'S NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

REASON FOR CONSULTATION:  R  L \_\_\_\_\_

**LIFESTYLE:** TOBACCO USE?  Y  N If yes, how much? \_\_\_\_\_/packs per day

ALCOHOL USE?  Y  N If yes, how much? \_\_\_\_\_/per day

### VITALS:

HEIGHT: \_\_\_\_\_

WEIGHT: \_\_\_\_\_

BLOOD PRESSURE: \_\_\_\_\_

DATE LAST CHECKED: \_\_\_\_\_

### LIST ALL MEDICATIONS AND DOSAGES:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

**ALLERGIES TO MEDICATIONS?**  Y  N

If yes, please list: \_\_\_\_\_

### ALLERGIC REACTIONS TO MEDICATIONS LISTED ABOVE:

**REACTION:**     Rash     Itchiness     Hives     Facial Swelling     Pain/Cramping

Diarrhea     Nausea     Vomiting     Loss of Consciousness

Tachycardia     Bradycardia     Chest Pain     Irregular Heartbeat

Wheezing     Shortness of Breath     Respiratory Distress     Difficulty Swallowing/Speaking

**SEVERITY:**     Very Mild     Mild     Moderate     Severe

**CONTINUED ON BACK OF FORM**

**PLEASE CHECK IF YOU HAVE HAD OR NOW HAVE ANY OF THE FOLLOWING:**

- |                                              |                                         |                                          |                                                                                                       |                                        |
|----------------------------------------------|-----------------------------------------|------------------------------------------|-------------------------------------------------------------------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Asthma         | <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Artificial joints                                                            | <input type="checkbox"/> Blood disease |
| <input type="checkbox"/> Back injury         | <input type="checkbox"/> Cancer         | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Epilepsy                                                                     | <input type="checkbox"/> Glaucoma      |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures       | <input type="checkbox"/> Hepatitis       | <input type="checkbox"/> Herpes                                                                       | <input type="checkbox"/> HIV/ AIDS     |
| <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Respiratory Problems                                                         | <input type="checkbox"/> Stroke        |
| <input type="checkbox"/> Swollen glands      | <input type="checkbox"/> Tuberculosis   | <input type="checkbox"/> Ulcers          | <input type="checkbox"/> Heart murmur                                                                 | <input type="checkbox"/> Angina        |
| <input type="checkbox"/> Prolapsed Valve     | <input type="checkbox"/> Pacemaker      | <input type="checkbox"/> Heart Condition | Are you pregnant? <input type="checkbox"/> N <input type="checkbox"/> Y <b><u>Please Tell Dr.</u></b> |                                        |

Have you ever been treated by Dr. Utlely in the past?  Y  N If yes, list the date of the most recent visit: \_\_\_\_\_

Does your family have a history of any illness?  Y  N If yes, please list: \_\_\_\_\_

Do you have any diseases, illnesses, conditions, or problems not listed above?  Y  N If yes, please list: \_\_\_\_\_

Please list all operations and dates within the last 10 years. \_\_\_\_\_

Please list all hospitalizations and dates within the last 10 years: \_\_\_\_\_

Are you now under the care of a physician?  Y  N If yes, name of physician and what condition is he/she treating: \_\_\_\_\_

Have you ever been to a Podiatrist?  Y  N If yes, explain: \_\_\_\_\_

**NOTICE TO PATIENTS REGARDING THE DESTRUCTION OF HEALTH CARE RECORDS:**

Pursuant to the provisions of subsection 7 of NRS 629.051: the health care records of a person who is less than 23 years of age may not be destroyed and the health care records of a person who has attained the age of 23 years may be destroyed for those records which have been retained for at least 5 years or for any longer period provided by federal law; and except as otherwise provided in subsection 7 of NRS 629.051 and unless a longer period by federal law, the health care records of a patient who is 23 years of age or older may be destroyed after 5 years pursuant to subsection 1 of NRS 629.051.

**CONSENT:**

The undersigned hereby authorizes the Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's needs. I also authorize the Doctor to perform any and all forms of treatment, injections, medication and therapy, which may be indicated. The doctor gives no guarantees and none are implied with any treatment. I understand responsibility for payment for services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered. I understand I will be charged \$40 for miscellaneous reports and/or forms to be filled out for disability or time off work. I understand I will be charged \$50 if I cancel a surgery that has been scheduled. I also understand that I will be charged \$20 if I change the date of a surgery that has already been scheduled.

I consent to allow Dr. Utlely's office to send me appointment reminders by email, text and/or automated voice calls.

**NOTICE OF PRIVACY PRACTICES:**

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

**SIGNATURE ON FILE:**

I authorize use of this form on all my insurance submissions. I authorize release of information to all my insurance carriers. I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers. I understand that my insurance will be billed as a courtesy and that I am responsible for all charges. **I understand that I am responsible for all co-pays, deductibles and co-insurance amounts as set forth by my insurance company, as well collecting any refunds or credits on my account. I authorize payment directly to my doctor. I understand all co-pays, deductibles and/or coinsurances is due at time services are rendered. I understand if account goes to collections, I will be charged a \$50 document preparation fee, plus all collection fees. I understand that I am responsible for any fee associated with unpaid balances including but not limited to court cost, collection fees and attorney fees.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

If other than patient, what is your relationship to patient: \_\_\_\_\_