DESERT FOOT & ANKLE

JOHN D. UTLEY, DPM ☐ Established patient ☐ New patient

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:__________________________ **Cross Streets:**______________________ **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:

☐ Anemia	☐ Asthma	☐ Arthritis	☐ Artificial joints	☐ Blood disease
☐ Back injury	☐ Cancer	☐ Diabetes	☐ Epilepsy	☐ Glaucoma
☐ High blood pressure	☐ Seizures	☐ Hepatitis	☐ Herpes	☐ HIV/ AIDS
☐ Jaundice	☐ Kidney disease	☐ Rheumatic fever	☐ Respiratory Problems	☐ Stroke
☐ Swollen glands	☐ Tuberculosis	☐ Ulcers	☐ Heart murmur	☐ Angina
☐ Prolapsed Valve	☐ Pacemaker	☐ Heart Condition	Are you pregnant? ☐ Y ☐ N	

Have you ever been treated by Dr. Utley 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.

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:____