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: _____

SSN_____-_____-_____ MOBILE #: (___)_____ LANDLINE#: (___)_____

Guardian SSN if patient is a Minor: _____-_____-_____

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

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? ☐ N ☐ Y Please Tell Dr.**	

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 $75 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. Utley'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 $300.00 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. I will also be charged $25.00 fee for a no show or same day cancellation.**

Signature _____ **Date** _____

If other than patient, what is your relationship to patient:_____

(04/2022)