DESERT PODIATRY
Dr. Robert B Grzywacz
3221 E. Warm Springs Road
Las Vegas, Nevada 89120
(702) 733-7617

PATIENT INFORMATION **PLEASE PRINT CLEARLY AND FILL OUT COMPLETELY**

SS# _____ Today's Date: _____

Patients Name: _____ D.O.B: _____

Mailing Address: _____

City: _____ State: _____ Zip code: _____

Home Phone: _____ Cell Phone: _____

Gender: Male_____ Female_____ Martial Status _____

Employer: _____ Employer Phone: _____

Ethnicity & Race: White/Caucasian _____ African American _____ Asian_____ Hispanic_____
American Indian _____ Pacific Islander _____ Other _____ Do not wish to provide _____

PRIMARY INSURANCE INFORMATION

Insurance: _____ ID/Policy #: _____

Insured's Name: _____ D.O.B: _____

SS #: _____ Group #: _____

Employer: _____Insured relationship to patient: _____

SECONDARY INSURANCE INFORMATION

Insurance: _____ ID/Policy #: _____

Insured's Name: _____ D.O.B: _____

SS #: _____ Group #: _____

Employer: _____Insured relationship to patient: _____

Emergency Contact: _____Phone #: _____

I hereby give permission for Dr. Robert B Grzywacz/Desert Podiatry to examine and render medical and/or surgical treatment. I agree to follow ALL prescribed treatment. I authorize photographs to be taken for medical education purposes.

I authorize Desert Podiatry/Dr. Robert B. Grzywacz to bill my insurance(s) on my behalf for services rendered. I authorize Desert Podiatry/Dr. Robert B. Grzywacz to release any information acquired in the course of my treatment needed for all medical insurance claims. I understand and acknowledge that I am financially responsible for all charges made to my account whether or not an insurance company is involved. I am responsible for any annual deductible, co-payments, co-insurance amounts and non-covered supplies and services. I understand that payment is due at the time services are rendered. I acknowledge it is my responsibility to inform Desert Podiatry/Dr. Robert Grzywacz of any insurance changes. Failure to do so may result in billing the wrong insurance company and expiration of the timely filing limit. I acknowledge that I am responsible for any charges for services rendered regardless of my insurance coverage. Our office makes every effort to obtain information from your insurance company prior to your visit. If the insurance company does not pay within 60 days, we reserve the right to begin billing you directly and ask that you contact your insurance carrier.

I understand that it is my responsibility to get a referral from my primary care physician if my insurance requires it. It is my responsibility to make sure that there is a current referral on file.

We accept cash, checks and major credit cards for your payment. We do charge a $1.00 credit card service fee for processing the credit card payment. There is a $25.00 return check fee, for all check payments that are returned for insufficient funds. We reserve the right to refuse check payments from you after the first incident.

If you should have a credit on your account after we have received all payments from your insurance company. All refunds are processed monthly. You can expect a refund check through the mail within 6 weeks of your request.

I understand that if my account should become delinquent after 90 days, it will be assigned to a collection agency and I will be responsible for all collection expenses, attorney's fees, court costs, filing costs and any charges that may be assessed by the collection agency. All fees will be added to your total balance when it is sent to the collection agency. We do understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

I acknowledge and understand all of the financial information provided to me. I hereby verify that the information I have provided is true and accurate best to my knowledge.

_____ _____

PATIENT/PARENT/GUARDIAN SIGNATURE **DATE**

MEDICAL HISTORY FORM

Name: _____ Age: _____

Current Height: _____ Weight: _____ Last Visit with Physician: _____

Name of Primary Care Physician/Referring Physician: _____

Address: _____Phone #: _____

Are you currently under the care of a physician: **Yes** **No**
If so, what are you being treated for_____

When was your last physical examination? _____

Has there been any change in your general health within the past year? **Yes** **No**

Have you been hospitalized or has a serious illness within the past five years? **Yes** **No**
If so, what was the problem? _____

What is the reason for your visit? _____

How long have you had this problem? _____

Is this due to an injury at work or automobile accident? **Yes** **No**

On a scale from 1 to 10, please rate your pain _____

Have you seen another physician for this same problem? **Yes** **No**

Please mark the following that apply to you.

Heart Disease _____ Diabetes _____ Asthma _____ Kidney Disease_____ Hepatitis or Liver Disease _____

Lung Disease _____ Anemia _____ Fainting Spells or Seizures_____ Arthritis_____ Cancer _____

Stomach Ulcer _____ STD_____ Other (specify) _____

Have you had abnormal bleeding associated with previous surgery or trauma? **Yes** **No**

Do you smoke? **Yes** **No** If Yes, how many packs a day? _____ How many years?_____

Do you drink Alcohol? **Yes** **No** How much a day? _____

Do you take street drugs? **Yes** **No** If Yes, What? _____ How long? _____

Are you currently taking any of the following?

Antibiotics _____ Anticoagulants (blood thinner) _____ High Blood Pressure Medicine: _____

Cortisone (steroids) _____ Tranquilizers _____ Antihistamines _____ Aspirin _____

Insulin_____ Heart Medication _____ Nitroglycerin _____ Other (specify) _____

Are you allergic or have you reacted adversely to the following:

Local Anesthetics	**Yes**	**No**
Penicillin or other antibiotics	**Yes**	**No**
Sulfa Drugs	**Yes**	**No**
Barbiturates, Sedative or Sleeping Pills	**Yes**	**No**
Aspirin	**Yes**	**No**
Iodine	**Yes**	**No**
Codeine or other Narcotics	**Yes**	**No**

Other (specify) _____

Are you currently receiving Chemotherapy or Radiation therapy? **Yes** **No**

Do you have any disease, condition or problem not listed? If so, explain

_____

_____

Please list current medications:

_____

_____

_____

Pharmacy Name: _____**Phone#:** _____

_____ _____

PATIENT/PARENT/GUARDIAN SIGNATURE **DATE**