Carson Valley Foot Care
1422 Mission Street
Gardnerville, NV 89410
P: 775-783-1122
F: 775-783-0868

New Patient Information

NEW PATIENT FORM – INITIAL VISIT		**Date Today:**
Last name:	First name:	MI:
Sex ◯ M ◯ F	Date of Birth:	Marital Status: ◯ S ◯ M ◯ D ◯ W
Patient SS#:	Race: ◯ Hispanic/Latino ◯ White/Caucasian ◯ Black ◯ Asian ◯ American Indian/Alaska Native ◯ Native Hawaiian/Pacific Islander ◯ Other	
Home Phone:	Work Phone:	
Cell Phone:	Email:	
Mailing Address:		
City:	State:	Zip:
IN CASE OF AN EMERGENCY, contact:		
Relationship:	Phone:	
Name of Primary Care Provider:		Date last seen:
Phone	Fax:	
How did you hear about us?	If referred, from whom?	
PERSON RESPONSIBLE FOR SERVICE IF DIFFERENT THAN LISTED ABOVE:		
Name:	SS#:	
Phone:	DOB:	
Address (if different from above):		
City:	State:	Zip:

Signature of Responsible Party:	**Date:**

REASON FOR VISIT:	
Describe the pain:	◯ sharp ◯ throbbing ◯ electrical sensation ◯ pins and needles ◯ aching ◯ shooting ◯ burning
Location of pain or primary complaint:	◯ ankle ◯ midfoot ◯ sole of foot ◯ big toe ◯ Achilles tendon ◯ arch ◯ ball of foot ◯ lesser toes ◯ heel ◯ forefoot ◯ top of foot ◯ toenails
How long has your problems been present?	◯ 1-3 days ◯ 3-6 weeks ◯ 6-9 months ◯ 3-7 days ◯ 6-8 weeks ◯ 9-12 months ◯ 1-3 weeks ◯ 3-6 months ◯ Greater than 1 year
Onset of condition or injury:	◯ Gradual over time ◯ Sudden due to activity or injury
Course/progression of condition:	◯ severe worsening ◯ steady/unchanging ◯ considerable/ good improvement ◯ moderate worsening ◯ mild improvement ◯ mild worsening ◯ moderate improvement
Aggravated by:	◯ any weight bearing ◯ running ◯ pressure to ball of foot ◯ standing ◯ exercise ◯ pressure from shoes ◯ walking ◯ bending ◯ pressure from jumping ◯ stooping
Home treatments to relieve your problem:	◯ rest ◯ ice ◯ elevation ◯ change shoe gear ◯ OTC padding ◯ in home whirlpool ◯ stretching ◯ trimming out your toenail yourself ◯ OTC anti-inflammatory medications (Motrin, Aleve, Tylenol, Aspirin, etc.) ◯ applying skin cream ◯ applying topical antibiotic ointment (triple antibiotic, bacitracin, Neosporin, etc.)
Improvement and relief with previous treatments:	◯ mild improvement ◯ considerable improvement ◯ worsening of condition ◯ moderate improvement ◯ no improvement
Activity level at work:	◯ sitting ◯ walking ◯ retired ◯ standing ◯ considerable movement/walking
Shoe size:	
Weight:	
Height:	

Mark appropriate ◯ as applicable.

GENERAL
◯ Diabetic ◯ Thyroid Disease

CARDIOVASCULAR
◯ Hypertension/ High Blood Pressure ◯ Pacemaker
◯ Heart Attack ◯ Congestive Heart Failure
Other _____

VASCULAR/CIRCULATION
◯ Blocked Arteries ◯ Blood clot
◯ High Cholesterol ◯ Stroke/CVA
Other _____

GASTROINTESTINAL
◯ Ulcer ◯ Liver Disorder
◯ Hepatitis (If yes, A/B/C)
Other _____

HEMATOLOGICAL
◯ Anemia ◯ Blood thinners
◯ Sickle Cell Disease ◯ Blood transfusion
Other _____

NEUROLOGICAL
◯ Seizures ◯ Polio
◯ Tremor
Other _____

MUSKULOSKELETAL
◯ Arthritis ◯ Rheumatoid Arthritis
◯ Gout
Other _____

IMMUNOLOGY
◯ HIV/AIDS ◯ Weakened Immune System
Other _____

ADDITIONAL
Cancer, if any (specify)
_____
_____
Joint Replacement, if any (specify) _____
_____
Surgeries, if any (type/date)
_____
_____
_____
Complications with surgery? ◯ Yes ◯ No
_____
_____

Mark the ◯ if you ever had:
◯ Measles ◯ Chicken Pox
◯ Mumps ◯ Pneumonia
◯ Rheumatic Fever ◯ Covid-19

Immunizations
◯ Measles ◯ Polio
◯ Mumps ◯ Tuberculosis
◯ Rubella ◯ Pneumonia
◯ Diphtheria ◯ Flu
◯ Tetanus ◯ Covid-19
◯ Chicken Pox

Family History (Cancer, Diabetes, etc.)
_____
_____

Nicotine/Alcohol Use
Alcohol ◯ Yes ◯ No *Amount:* _____
Nicotine/Cigarettes ◯ Yes ◯ No *Amount:* _____

Medication Allergies
_____
_____

Food/Plant Allergies
_____
_____

Medications currently taking (including aspirin)
_____
_____

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PATIENT DECLARATION

I AM AWARE THAT IF CARSON VALLEY FOOT CARE IS CONTRACTED WITH MY INSURANCE, IT DOES NOT NECESSARILY MEAN MY INSURANCE WILL COVER MY VISIT.

I UNDERSTAND THAT CARSON VALLEY FOOT CARE DOES NOT HAVE ACCESS TO MY INSURANCE POLICY, AND THEREFORE I NEED TO BE AWARE OF MY COVERAGE. I WILL INFORM THE OFFICE SO THAT THEY CAN ASSIST ME IN UNDERSTANDING.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY OUTSTANDING BALANCES THAT MY INSURANCE DOES NOT PAY. CARSON VALLEY FOOT CARE IS HERE TO ASSIST YOU IN EVERY POSSIBLE WAY OF UNDERSTANDING YOUR COVERAGE WITH THIS OFFICE.

POLICY AND PROCEDURES

1. Prior to being seen a copy of all insurance cards needs to be provided to the office. If there is no insurance the visit will need to be paid in full unless other arrangements with the office have been made.
2. Carson Valley Foot Care confirms appointments 1 business day prior to the visit, because of that we will have to assess a $50.00 charge for any appointment that does not have 24-hour notification of cancellation.
3. Insurance companies set the amount of copays and deductibles; Carson Valley Foot Care has **NO** control over the amount of your copay or deductible. All copays are due at the time of service. All deductibles and coinsurance are due 20 days after the insurance company has processed the claim. Carson Valley Foot Care sends statements to the provided address of each patient. Any balance that has no payment received after 90 days will be sent to collections. We do offer payment plans with no interest rates to help our patients with any outstanding balance.
4. Unfortunately, due to the incorrect information that has been consistently provided to our office, we will now need to charge $10.00 to patients for any rebilling due to incorrect insurance information, demographics, etc.
5. All patients have the right to their medical records. Once requested we will provide the records to the patients within 10 business days. There will be a charge of 60 cents per page.
6. Carson Valley Foot Care will be more than happy to mail records, supplies, etc. to patients, there is a $10.00 mailing fee that will be charged to the account.
7. There will be a $25.00 charge for any returned check.

Signature: _____ **Date:** _____