MESILLA VALLEY FOOTCARE PHYSICIANS

Date(Fecha): _____ **Patient sign in time**(El Horario): _____

Name (Nombre): _____ **DOB** (Feche de Nacimiento): _____

Reason for today's visit (Razon de su visita)*?* _____

_____

Below is For Clinic staff (only) / Fondo Para el personal de la clinica (solo)

Height _____ , **Weight** _____

Diabetic? ***yes / no , type I or type II:*** _____ , ***Last A1C:*** _____

Other health concerns? _____

Primary Care Dr: _____ **Phone #** _____

Date last seen PCP?: _____

Pharmacy: _____ **Phone #** _____

REMEMBER TO INCLUDE Right or Left

Wound Location & Size: _____ **Debridement:** yes / no

_____

_____

Constitutional: _____

Nails: _____

Skin: _____

Muscular / Skeletal: _____

Deformities: _____

Uses orthotics or other braces: yes / No For what: _____

Gait: _____ **Mobile Assistance:** _____

Cardiovascular: Mono: Pos / Neg _____ , **Sensation : yes / No** _____

Pulses: LDP _____ **RDP** _____ **PT** _____ , **Swelling / Edema** _____

Injection: Yes / No _____ DX: _____

Nails cut: Yes / No **Calluses removed:** Yes / No , Location/method? _____

Xrays: Rt / Lt ..... Foot / Ankle / Calcaneal ..... **Views:** _____

Additional procedure: _____

_____

ORTHOTICS DISPENSED? Yes / No Size: _____ ***Patient signature:*** _____

MESILLA VALLEY FOOTCARE PHYSICIANS / Review of Systems

Name (Nombre): _____ **DOB** (Feche de Nacimiento): _____

***Are you diabetic** (Es diabetico)? yes / no , type I or type II: _____ , Last A1C:_____*

Have you had any of the following medical conditions (Ha tenido alguna de las siguientes condiciones médicas)?
(*circle all that apply / circule, los que appliquen*)

Respiratory (Respiratorio): **chest pain, pneumonia, bronchitis, asthma, emphysema, TB or positive PPD**

Cardiovascular: **history of MI, stroke, high blood pressure, cramps feet/legs, swelling feet/ankles**

Gastrointestinal: **heartburn, indigestion, ulcers, liver disease, gall bladder disease, kidney disease**

Endocrine (Endocrino): **thyroid disorder, gout, hormonal therapy**

Musculoskeletal (Musculoesqueletico): **arthritis, low back pain, other:** _____

Hermatology (Hematologia): **anemia, bleeding tendency, easy bruising**

Neuro: **seizures, weakness, paresthesia's**

Psychiatric (psiquiátrica): **mood alterations, depression, anxiety**

Any other health concerns (cualquier otro problema de salud)?_____

Do you have a personal history of cancer (Tiene antecedentes personales de cáncer)? _____

Allergies / Alergias

_____
_____
_____
_____
_____
_____
_____
_____

Medications / Medicacion

_____
_____
_____
_____
_____
_____
_____
_____

Surgical history / Antecedentes cirugia

_____
_____
_____
_____
_____

Social history / historia social

smoker (fuma)? no / yes, _____ per day
chew tobacco (masticar tabaco) ? yes / no
drink alcohol (bebe alcohol)? yes / no
Medical Marijuana (marihuana medicinal)? no / yes
recreational drugs (drogas recreativas)? yes / no

Pharmacy (farmacia): _____ **Phone (Telefono) #** _____

Primary Care Dr (medico de atencion primaria): _____ **Phone (Telefono) #** _____

Patient/Guarantor Signature (Firma del paciente / garante) : _____ Date: _____

MESILLA VALLEY FOOT CARE PHYSICIANS

Date: _____

Patient Name: _____ **DOB:** _____

Soc Sec #: _____ **Sex:** male / female **Marital Status:** _____

Mailing Address: _____

City State Zip

Physical Address: _____

City State Zip

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Email Address:** _____

Employment Status (Circle One) : Employed Retired Unemployed Full-time Student Child Other

(If applicable)Employer: _____ **Occupation:** _____

Primary Ins: _____ Policy holder name/DOB: _____

Secondary Ins: _____ Policy holder name/ DOB: _____

Emergency Contact: _____

Relationship: _____ **Best Contact Number:** _____

Primary Care Physician: _____

Race: declined White Hispanic/Latino American Indian Black/African American Asian

Preferred spoken Language: _____

INSURANCE ASSIGNMENT/RELEASE OF INFORMATION: *I request that payment of authorized Insurance benefits be made on my behalf to Mesilla Valley Foot Care for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration, and any information needed to determine the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurers or agency shown. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Insurance carrier.*

I hereby authorize and consent to evaluation and treatment as determined by the above physician.

Patient or Guarantor Signature: _____ **Date:** _____

Mesilla Valley Foot Care Physicians
Rolando C. Cadena, DPM
2930 Hillrise Dr., Ste 4
Las Cruces NM 88011
Tel (575)522-3330 Fax (575)522-7853

I have received a copy of the Privacy Practice Notice.

Patient's Signature: _____

Date: _____

Parent/Guardian if minor: _____

Date: _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care Professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health Professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of Coverage such as an automobile insurer, or from credit care companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Options. Your health information may be used as necessary to support the day-to-day activities and management of Rolando C Cadena DPM. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseased to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any other purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use of disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Rolando C. Cadena, DPM Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right and Revise Privacy Practices

As permitted by law. We reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our Records Manager.

Complaints

Records Manager
Rolando C. Cadena, DPM
2930 Hillrise Dr., Ste 4
Las Cruces NM 88011

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

Records Manager
Rolando C. Cadena, DPM
2930 Hillrise Dr., Ste 4
Las Cruces NM 88011
Tel 575-522-3330
Fax 575-522-7853

Effective Date

This notice is effective on or after October 1, 2002