Dr. Nahad Wassel
Foot & Ankle Surgeon

PATIENT REGISTRATION

Name: ______________________________ Age: ________ Birthdate: ______________

Address: ____
Street *City* *State* *Zip*

Social Security: ______________________ Sex: M F Other Marital Status: S M D W

Preferred Phone: (_______)______________________ Email: ______________________

Race: ______________________ Ethnicity: ______________________

Occupation: ____

Emergency Contact: ______________________ Phone: (_______)______________________

Primary Care Physician: ______________________ Last Visit: ______________________

Pharmacy, Address & Phone: ____

☐ *By checking this box, I authorize Stride Foot & Ankle to obtain my prescription history electronically.*

INSURANCE WAIVER: I agree to accept financial responsibility for services which are denied by my insurance company on the basis of eligibility, co-payments, deductible, non-covered items and/or procedures stated as more extensive than the insurance will cover. I also understand that just because my insurance company has certain benefits, I may be responsible due to their disclaimer. I also understand that even though assignment may be taken with my insurance company, I am still responsible for any balance not paid with my insurance within 60 (sixty) days of the date of service. Please understand if the account becomes delinquent and an outside agency is needed for collections on this account, you the patient will become responsible for any and all collections and/or legal fees. By signing below, I authorize payment of all medical benefits to Stride Foot & Ankle for all services rendered.

Signature: ______________________________________ *Date*: ______________

If patient is a minor, or has a representative, please supply the following information:

Guardian/Representative Name: ______________________ Relationship: ______________

Signature: ______________________________ Date: ______________

FEES: We expect all co-pays and deductibles to be paid at the time of service. If we are not a contracted provider for your insurance we will still bill them but payment in full is expected. Please remember that we only process claims in our system the way your insurance company has processed them. Any complaints or problems with the way claims are processed need to be taken up with your insurance company. To the best of my knowledge I have supplied correct information to the above form and I have read and understand the FEES CLAUSE. I give permission to Dr. Nahad Wassel to render the proposed podiatric examination and treatment that will be explained to me.

Insurance Payment Order To: ______________________________ *(Insurance Company)*

I authorize and direct you to pay directly to: Stride Foot & Ankle, 3662 E Sunset Rd, Ste 115, Las Vegas, NV 89120, the amount due me in my pending claim for Basic Medical, Major Medical and/or Surgical treatment or services by reason of such treatment or services rendered.

Signature: ______________________________________ *Date*: ______________

INSURANCE INFORMATION: If we have obtained copies of your insurance card, you do not need to fill out this section

Primary Insurance: ______________________ ID #: ______________________

Name of Insured: ______________________ DOB: __________ Relationship: ______________

Secondary Insurance: ______________________ ID #: ______________________

Name of Insured: ______________________ DOB: __________ Relationship: ______________

ACKNOWLEDGMENT OF RECEIPT OF 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.

Patient Name: ______________________________________ Date: ______________

STRIDE FOOT & ANKLE PATIENT HISTORY

Name: ____________________ Age: ________ Birthdate: ______________

Allergies: ______________________________

Allergies to: *Adhesive:* Y N *Anesthesia:* Y N *Latex:* Y N *Nickel/Silver:* Y N *Seafood:* Y N

MEDICAL HISTORY Please circle Yes or No by any of these conditions you currently have or have had in the past:

Asthma	Yes	No	Arthritis	Yes	No
Emphysema	Yes	No	Back Problems	Yes	No
Pneumonia	Yes	No	Stomach Problems	Yes	No
High Blood Pressure	Yes	No	Ulcers	Yes	No
High Cholesterol	Yes	No	Bladder Problems	Yes	No
Headaches	Yes	No	Loss of Balance	Yes	No
Numbness/Tingling	Yes	No	Cancer	Yes	No
Stroke	Yes	No	Hepatitis	Yes	No
Heart Attack	Yes	No	HIV Virus	Yes	No
Seizures	Yes	No	Depression	Yes	No
Bleeding Disorders	Yes	No	Diabetes	Yes	No
Kidney Problems	Yes	No	**If yes, what is your most recent blood sugar #: ________ mg/dl*		
Thyroid Disease	Yes	No	Other: ______________________		

What other doctors/specialists do you see: ______________________________

____

Significant Family History *(Diabetes, Cancer, etc)*: ______________________________

____

Surgeries in the past 10 years *(Please include year)*: ______________________________

____

____

Alcohol Consumption: 0 2 4 6 >6 Drinks per week

Caffeine Consumption: 0 1 2 3 >4 Drinks per day

Tobacco Usage: 0 <1 2 3 Packs per day

*Years of Tobacco Use: ______________ years

*Previous Tobacco User? Y N; Quit Date: ________

Current Medications:

______________ ______________ ______________

______________ ______________ ______________

______________ ______________ ______________

______________ ______________ ______________

Problem(s) you are being seen for today: ______________________________

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____

Referred by: ______________________________

By my signature below, I certify the information I provided on and in connection with this form is true and correct to the best of my knowledge.

Signature: ______________________________ *Date*: ______________