PATIENT REGISTRATION FORM

DATE ___/___/_____ EMAIL_____

PATIENT'S NAME_____

ADDRESS_____

CITY_____ STATE _____ZIP_____

HOME PHONE: (___) ____-_____

CELL PHONE: (___) ____-_____

SSN: ____ - ____ - _____ *BIRTH-DATE:* ___/___/_____

☐SINGLE
☐MARRIED
☐DIVORCED
☐OTHER_____

GENDER
☐F
☐M

PRIMARY CARE PROVIDER:

NAME_____ PHONE NUMBER_____

REFERRING PHYSICIAN:

NAME_____ PHONE NUMBER_____

PHARMACY INFORMATION:

ADDRESS/CROSS STREETS_____

PHONE NUMBER_____

EMERGENCY CONTACT:_____

RELATIONSHIP:_____ PHONE #_____

Myo Cardiovascular Clinic
Myo Vein/Cosmetic Center

Request for Confidential Communication of Protected Health Information

I _____ give permission to Dr. Foghi's office to discuss my protected health information (PHI) with named persons below.

Those who we may communicate with regarding your health information, or for appointments:

Name: _____

Relationship: _____ Telephone: _____

Name: _____

Relationship: _____ Telephone: _____

Note: This request will remain in effect until you notify us of a change.

Signature: _____ Date: _____

Printed Name: _____

Relationship (if not patient, who is signing) _____

Patient's Date of Birth: _____ Patient's SS#: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I, the undersigned, have been made aware of my rights as a patient under the "Health Information Portability and Accountability Act" as posted in the office. I further understand that I may request a printed copy of these rights at any time.

Printed Name of Patient: _____

Signature: _____

Authority to Sign if Not Patient: _____

Date: _____

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CONSENT FOR CARE AND TREATMENT

I, the undersigned, having legal authority to do so, do hereby agree and give consent for Myo Cardiovascular Clinic to furnish medical care and treatment as considered necessary and proper in diagnosing or treating my/his/her physical and mental condition.

HIPAA

I, the undersigned, have been made aware of my rights as a patient under the "Health Information Portability and Accountability Act" as posted in the office. I further understand that I may request a printed copy of these rights at any time.

MISSED APPOINTMENTS

Did you know we are averaging 20 or more missed appointments per week? This not only affects the quality of care that we provide but also makes it incredibly difficult to schedule prompt and convenient appointment times for both existing and new patients. We find ourselves in the unenviable position of having to manage this problem without inflaming the delicate relationship that we have with our patients.
If you do not give us advance notice that you will be unable to make an appointment you may be responsible to pay a $25.00 missed appointment fee.

Thank you in advance.

I have read and understand the statement noted above.

Patient/Guardian/Responsible Party _____ Date _____

Please Print Your Name _____ Date _____

Myo Clinic Representative _____ Date _____

Myo Cardiovascular Clinic
Myo Vein/Cosmetic Center
1740 Grande Blvd. SE Ste. D
Rio Rancho, NM 87124
Phone: 505-892-0402
Fax: 505-892-5544

Do I Need a Test for PAD?

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, or kidneys, become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk for stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Name:_____ Date:_____

Circle "Yes" or "No":

				Test for PAD
1.	Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest?	Yes	No	☐
2.	Do you experience any pain at rest in your lower leg(s) or feet?	Yes	No	☐
3.	Do you experience foot or toe pain that often disturbs your sleep?	Yes	No	☐
4.	Are your toes or feet pale, discolored, or bluish?	Yes	No	☐
5.	Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 weeks)?	Yes	No	☐
6.	Has your doctor ever told you that you have diminished or absent pedal (foot) pulses?	Yes	No	☐
7.	Have you suffered a severe injury to the leg(s) or feet?	Yes	No	☐
8.	Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)?	Yes	No	☐

Patient Signature:_____

Physician Signature:_____ Date :_____

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Do I Need a Test for CVI?

Chronic Venous Insufficiency (CVI) is a serious circulatory problem in which the leg veins cannot pump enough blood back to your heart. It affects over 2.5 million Americans, most over the age of 40. Symptoms of CVI include varicose veins, skin problems, leg and ankle swelling, tight calves, and legs that feel heavy, tired, restless, or achy. Factors that can increase the risk of CVI include pregnancy, obesity, smoking, standing or sitting for long periods of time and not getting enough exercise. Answers to these questions will determine if you are at risk for CVI and if a vascular exam will help us better assess your vascular health status.

Name:_____ Date:_____

Circle "Yes" or "No":

				Test for Venous Disease
1.	Are your legs swollen, painful, red or warm to the touch?	Yes	No	☐
2.	Have you had a blood clot in a vein that caused inflammation, pain or irritation?	Yes	No	☐
3.	Do you have varicose veins (veins that are enlarged or swollen and raised above the surface of the skin) in the legs?	Yes	No	☐
4.	Have you had a Deep Vein Thrombosis (DVT) in the past and are experiencing pain, swelling, changes in skin color, cellulites, or non-healing ulcers?	Yes	No	☐
5.	Do your legs feel heavy, tired, restless or achy?	Yes	No	☐
6.	If you push on your swollen foot, ankle or leg for 10 seconds and release, does your fingerprint leave a dimple?	Yes	No	☐
7.	If your feet, ankles and legs are swollen, does the skin look stretched or shiny?	Yes	No	☐
8.	Do you have an ulcer on the inside of your ankle?	Yes	No	☐

Patient Signature:_____

Physician Signature:_____ Date :_____