



DR. SHANE D. DRAPER  
DR. QUINN D. LINDSTROM  
Foot & Ankle Specialists  
SUE WINDOUS,  
FNP-BC

**PATIENT INFORMATION**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Social Security # \_\_\_\_\_  
Email \_\_\_\_\_

Sex: M F Referred by: \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Employer/Address \_\_\_\_\_

Work Phone \_\_\_\_\_

Insurance Coverage: \_\_\_\_\_ If Not, Payment in Full is Required at Time of Service

**PRIMARY INSURANCE-** We will need to make a copy of your insurance card, front & back

Insurance Company \_\_\_\_\_ Policy Holder \_\_\_\_\_

Member ID# \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder Date of Birth \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Policy Holder Social Security # \_\_\_\_\_ Address \_\_\_\_\_

Policy Holder Employer/ Address \_\_\_\_\_

**SECONDARY INSURANCE-**

Insurance Company \_\_\_\_\_ Policy Holder \_\_\_\_\_

Member ID# \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder Date of Birth \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Policy Holder Social Security # \_\_\_\_\_ Address \_\_\_\_\_

Policy Holder Employer/ Address \_\_\_\_\_

**AUTHORIZATION**

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the medical staff at Ruby Vista Medical to help determine appropriate treatment. If there is any change in medical status, I will inform the Dr. Shane Draper, Dr. Quinn Lindstrom, or Sue Windous FNP-BC. I give permission to Dr. Shane Draper, Dr. Quinn Lindstrom, or Sue Windous FNP-BC to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my lower extremities. I authorize my insurance company to pay to Dr. Shane Draper or Dr. Quinn Lindstrom, all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize Dr. Shane Draper or Dr. Quinn Lindstrom to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

**COPAY OR PAYMENT IS DUE AT TIME OF TREATMENT**

775.738.1100

2078 Idaho Street | Elko, Nevada 89801



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Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

Medications and Dosages: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Drug Allergies: \_\_\_\_\_

\_\_\_\_\_

Marital Status: M S D W

# of Children: \_\_\_\_\_

Employed: Full time Part time Retired Student

Nutrition: Excellent Good Average Poor

Exercise: Walking Cardio Weights None

Exercise Frequency: Regular Occasional Never

Smoking: Yes No

Current: Amount per day: \_\_\_\_\_

Former: Quit Date: \_\_\_\_\_

Alcohol Use: Yes No Amount: \_\_\_\_\_

Cannabis Use: Yes No Amount/Type: \_\_\_\_\_

Illicit Drug Use: Yes No

Signed form of DNR (Do not Resuscitate): Yes No



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**PATIENT CHRONIC ILLNESSES:**

Anemia	Gout
Arthritis, Degenerative	Hepatitis
Arthritis, Rheumatoid	High Blood Pressure
Asthma	High Cholesterol
Atrial Fibrillation	HIV/AIDS
Back Pain	Hyperthyroidism
Cancer _____	Hypothyroidism
Cardiac Murmur	Kidney Stones
Chronic Kidney Disease	Obesity
Chronic Pain Syndrome	Obstructive Sleep Apnea
Congestive Heart Failure	Osteopenia
Coronary Artery Disease	Osteoporosis
COPD	Peripheral Vascular Disease
Deep Vein Thrombosis	Restless Leg Syndrome
Depression	Stroke
Diabetes Type I	Tuberculosis
Diabetes Type II	Varicose Veins
Eczema	

Other: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SURGERIES:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



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**FAMILY HISTORY:**

**Mother:** Living / Deceased

Alzheimer's Arthritis: Rheumatoid / Degenerative Asthma Coronary Artery Disease  
Cancer: \_\_\_\_\_ High Cholesterol Depression Diabetes: Type I / Type II  
High Blood Pressure Migraines Obesity Osteoporosis Kidney Disease Stroke  
Low Thyroid High Thyroid Foot Problems Unknown Other: \_\_\_\_\_

**Father:** Living / Deceased

Alzheimer's Arthritis: Rheumatoid / Degenerative Asthma Coronary Artery Disease  
Cancer: \_\_\_\_\_ High Cholesterol Depression Diabetes: Type I / Type II  
High Blood Pressure Migraines Obesity Osteoporosis Kidney Disease Stroke  
Low Thyroid High Thyroid Foot Problems Unknown Other: \_\_\_\_\_

**Siblings:** (#\_\_ Brothers, #\_\_ Sisters) Living / Deceased

Alzheimer's Arthritis: Rheumatoid / Degenerative Asthma Coronary Artery Disease  
Cancer: \_\_\_\_\_ High Cholesterol Depression Diabetes: Type I / Type II  
High Blood Pressure Migraines Obesity Osteoporosis Kidney Disease Stroke  
Low Thyroid High Thyroid Foot Problems Unknown Other: \_\_\_\_\_

**Other Family History:** Unknown Adopted

Alzheimer's Arthritis: Rheumatoid / Degenerative Asthma Coronary Artery Disease  
Cancer: \_\_\_\_\_ High Cholesterol Depression Diabetes: Type I / Type II  
High Blood Pressure Migraines Obesity Osteoporosis Kidney Disease Stroke  
Low Thyroid High Thyroid Foot Problems Unknown Other: \_\_\_\_\_

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