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| **DEMOGRAPHICS** |

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_

Sex: **€** Male **€** Female

**€** Married **€** Single **€** Divorced **€** Widow

SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: (\_\_\_\_\_ )\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Contact Method: **€** Home **€** Cell

Text Notification **€** Yes **€** NO Email Notification**€** Yes**€** No

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please List Who Referred You: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **PATIENTS UNDER 18 YEARS OLD ONLY** |

Guardians Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Emergency Contact Information** |

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **INSURANCE INFORMATION** |

Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **PHARMACY** |

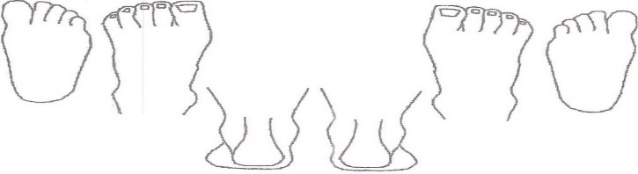
**Preferred Pharmacy and Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **CHIEF COMPLAINT** |

What is the problem/condition you are having?

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

Please indicate the source of problem on the diagrams:



Right Foot

Left Foot

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Current Pain Level: \_\_\_\_\_ Worst Pain Level: \_\_\_\_

Is this complaint due to an injury **€** Yes **€** No

Is this injury work related **€** Yes **€** No

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| **Please indicate which problem(s) you are experiencing:**  Numbness/Burning/Tingling in Foot **€** Yes **€** No  Cramps and Spasms **€** Yes **€** No  Swelling of Leg(s) **€** Yes **€** No  Leg Pain **€** Yes **€** No  Ankle Pain **€** Yes **€** No  Heel Pain **€** Yes **€** No  Foot Pain **€** Yes **€** No  Calluses **€** Yes **€** No  Plantar Warts/Skin Lesions **€** Yes **€** No  Wound/Ulcer **€** Yes **€** No  Deformed/Fungal Toenails **€** Yes **€** No  Ingrown Toenails **€** Yes **€** No  Weakness in Leg/Ankle/feet **€** Yes **€** No  Balance Problems **€** Yes **€** No |

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| **PAST MEDICAL HISTORY** | |
| **€** Diabetes | **€** Neuropathy |
| **€** Arthritis | **€** RSD / CRPS |
| **€** Osteomyelitis  **€** Fibromyalgia | **€** Peripheral Vascular Disease |
| **€** History of Pulmonary Embolism | **€** Kidney Disease  **€** Venous Insufficiency |
| **€** Heart Disease  **€** High Blood Pressure | **€** Stent Placement in Lower Extremity |
| **€** GERD/Gastric Ulcer  **€** Skin Cancer  **€** Liver Disease | **€** Implant: Pacemaker or Defibrillator  **€** Other: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **PAST SURGICAL HISTORY** |

Please list any past surgeries:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Did you tolerate anesthesia well? € Yes € No

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| **FAMILY/SOCIAL HISTORY** |

**Mother:** € Deceased € Living

**Medical History:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Father:** € Deceased € Living

**Medical History:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you use tobacco?** **€** Yes **€** No

If **YES**:

Type: **€** Pipe **€** Cigar **€** Cigarettes  **€** Chew

How Often: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

If you are a FORMER TOBACCO USER:

How long ago did you quit? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you use Alcohol?** € Yes € No

If **YES**:

How Often: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have a history of Diabetes?** **€** Yes  **€** No

**IF YES:** **€** Type I  **€** Type II **€** Other: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name of Monitoring Physician: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date Last Seen by this Physician: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name of Primary Care Physician: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Last Date Seen By PCP: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **REVIEW OF SYSTEMS** |

Please ***circle*** any other significant medical history that you feel would be pertinent to your treatment at our facility:

**General:** Weight Gain-Loss; Change in strength or exercise tolerance; Fever; Chills; Fatigue; Lethargic; HIV/AIDS

**HEENT:** Headaches/Migraines; Dizziness; Traumatic Brain injury; Blurred Vision; Change in Vision; Hearing Loss; Ringing of Ears; Nose Bleeding; Trouble Breathing; Running Nose; Dental difficulties; Bleeding gums; Use of dentures/Implants; Neck Stiffness; Noted Masses on Neck; Frequent Sore Throat; Thyroid Problem; Trouble Swallowing

**Lungs:** Wheezing; Coughing of Blood; Chronic Cough; Shortness of Breath; Infection of Lungs

**Heart:** Chest Pain; Palpitations; Heart Valve Problems; Fainting; Infections of Heart

**Abdomen:** Loss of Appetite; Diarrhea; Nausea/Vomiting; Bloody Stool

**GU:** Frequent Urination; Urinary Tract Infection; Change in nature of urine.

**Gyn:** Change in menses; Pain with Menses; Vaginal discharge; Pelvic pain; Menopausal

**Dermatologic:** Callus; Wound; Rash/Itching; Change in Mole; Deformed Toenails; Infection of Skin

**Musculoskeletal:** Pain in muscles or joints; limitation of Joint or Joint Stiffness; Foot/Ankle Swelling; Infection of Bone

**Neurologic:** Weakness; Tremor; Seizures; Memory Loss; Trouble with Balance; Numbness or Loss of Sensation

**Psychiatric:** History of Depression; History of Anxiety; Trouble Sleeping; Thoughts of Suicide

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

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

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| **TREATMENT CONSENT** |

I hereby consent and give my permission to the doctor (and the doctor’s assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

**Patient / Guardian Signature Date**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medication List/Allergies Passport**

Please fill this form out completely and bring it with you when you visit any Medical Professional/Pharmacy. Include all medications (prescribed and over the counter) and vitamins that you are currently taking.

**Medications (PRINT)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Dose** | **How often** | **Prescribing Doctor** |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| 5. |  |  |  |
| 6. |  |  |  |
| 7. |  |  |  |
| 8. |  |  |  |
| 9. |  |  |  |
| 10. |  |  |  |
| 11. |  |  |  |
| 12. |  |  |  |
| 13. |  |  |  |
| 14. |  |  |  |
| 15. |  |  |  |

**Drug Allergies**

|  |  |  |  |
| --- | --- | --- | --- |
| **Allergen**  (Drug, Food, Environment) | **Severity**  (Mild, Moderate, Severe) | **Reaction**  (Anaphylaxis, Rash) | **Onset**  (Childhood, Adult, Unknown) |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| 5. |  |  |  |

HIPPA NOTICE OF PRIVACY PRACTICES

My signature on this document acknowledges that I have read Carl M. Salvati, D.P.M. HIPPA Notice of Privacy Practice

LIFETIME AUTHORIZATION

INSURANCE ASSIGMENTS AND AUTHORIZATION TO RELEASE INFORMATION

I. RELEASE OF INFORMATION- I, the below named patient, do hereby authorize any physician examining and/or treating me to release to any third payer (such as insurance company or governmental agency, e.g.-Blue Cross Blue Shield of Florida or Medicare) any medical, psychiatric condition, alcohol or drug related condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determine a claim for payment for such treatment and/or diagnosis.

II. PHYSICAIN INSURANCE ASSIGNMENT- I, the below named patient, hereby authorize payment directly to any physician examining or treating me or any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

III. MEDICARE/MEDICAID- Patient’s certification authorization to release information and payment request. I certify that the information given by me in applying for payment under TitleXVII/XIX of the Social Security Administration Division of Family Services or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

IV. I PERMIT A COPY OF THIS AUTHORIZATION AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIANS OFFICE. The assignment will remain in effect until revoked by me in writing.

V. CONSENT FOR TREATMENT- I, the below named patient, hereby give my consent for treatment to all physicians associated with Armando Gonzalez, D.P.M or Carl M. Salvati, D.P.M.

VI. CONSENT TO DISCUSS MEDICAL CONDITION OR RELEASE RECORDS: I, the below named patient do authorize Armando Gonzalez D.P.M or Carl M. Salvati, D.P.M. to discuss my medical condition with, or release my medical records to the below named person(s):

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it’s my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third-party payor within reasonable period of time not to exceed 60 days. If the amount is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney’s fees and costs of collection.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUBSCRIBER (if different from patient) Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN

Florida law (Section 817.5655, Florida Statutes) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

During the course of your care at Marion County Podiatry Specialists, it may be medically necessary to obtain a blood, urine, stool, tissue or other type of biological specimen for analysis. This analysis **will not** involve the examination of your DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and then transferred to a third party for disposal in accordance with all local, state and federal requirements.

It may also be the case that a biological specimen (such as blood, urine, hair, bodily fluids, etc.) from you may be deposited on medical instruments, bedding, clothing or other objects. These objects may then be transferred to a third party for cleaning or disposal.

By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with Marion County Podiatry Specialists to a third party as set forth above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

Name Print

Signature of Patient

Date

Medical Records Request Form

Marion County Podiatry Specialists

Carl M. Salvati, D.P.M.

812 NE 25th Ave., Suite A 3300 SW 33RD Road

Ocala, FL 34470 Ocala, FL 34474

|  |
| --- |
| **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Name(Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **D.O.B.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **I hereby give authorization to release my medical records from:**  **Name of Medical Facility/Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Labs**  **Last office notes**  **Medication List**  **X-rays**  **MRI’s**  **Operative Report**  **All Medical Records**  **Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

P: 352-351-4444 F: 352-351-4920 P:352-351-4444 F: 352-351-4920

Fax To:

Fax (352) 351-4920

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_