MARION COUNTY
PODIATRY SPECIALISTS

Board Certified, American Board of Podiatric Medicine

Dr. Carl M. Salvati, DPM
812 N.E. 25th Ave., Ste A
Ocala, Florida 34470
Office: (352) 351-4444 Fax: (352)351-4920

Dr. Carl M. Salvati, DPM
3300 SW 33rd Road
Ocala, Florida 34474
Office: (352) 351-4444 Fax: (352)351-4920

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: _____

PATIENTS UNDER 18 YEARS OLD ONLY

Guardians Name: _____
Relation: _____
Phone: (_____) _____-_____

EMERGENCY CONTACT INFORMATION

Name: _____
Contact Number: _____
Relationship: _____

INSURANCE INFORMATION

Primary Insurance: _____
Policy Number: _____
Secondary Insurance: _____
Policy Number: _____

PHARMACY

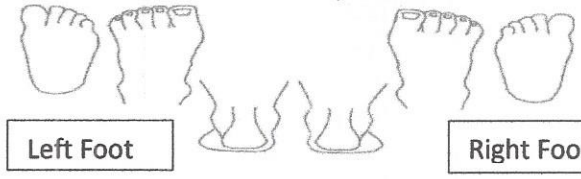
Preferred Pharmacy and Location: _____

CHIEF COMPLAINT

What is the problem/condition you are having?

_____

Please indicate the source of problem on the diagrams:



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

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

PAST MEDICAL HISTORY

☐ Diabetes
☐ Arthritis
☐ Osteomyelitis
☐ Fibromyalgia
☐ History of Pulmonary Embolism
☐ Heart Disease
☐ High Blood Pressure
☐ GERD/Gastric Ulcer
☐ Skin Cancer
☐ Liver Disease
☐ Neuropathy
☐ RSD / CRPS
☐ Peripheral Vascular Disease
☐ Kidney Disease
☐ Venous Insufficiency
☐ Stent Placement in Lower Extremity
☐ Implant: Pacemaker or Defibrillator
☐ Other: _____

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PAST SURGICAL HISTORY

Please list any past surgeries:

_____

_____

_____

Did you tolerate anesthesia well? ☐ Yes ☐ No

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: _____

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: _____
_____

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**

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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.			

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: _____

Medical Records Request Form

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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:** _____

Fax To:

Fax (352) 351-4920

Patient Signature: _____ Date: _____