Marion County Podiatry Specialists

Carl M. Salvati, D.P.M.
812 N.E. 25th Avenue Suite A
Ocala, Florida 34470 Phone 352-351-4444

Date: _____/_____/_____

Name: _____ DOB: ____-____-____ Age: _____ Sex M F

Phone ( ) _____-_____ S.S.# _____-_____-_____ Marital S M D Widow

Address: _____ City _____ State _____ Zip _____

Email: _____

If under 18. Mother's Name: _____ Phone ( ) _____

Father's Name: _____ Phone ( ) _____

Employment Name: _____ Phone ( ) _____

Spouse Name: _____ Phone ( ) _____

Primary Insurance Name: _____

Policy Number: _____ Group Number: _____

Insured's Name: _____

Secondary Insurance Name: _____

Policy Number: _____ Group Number: _____

Emergency Contact Name: _____

Relationship: _____ Phone: ( ) _____

Patient Information: Required by U.S. Gov. Please Circle

Race: Asian American Indian Black-African American Polynesian White

Ethnicity: Hispanic/Latino Non-Hispanic

Contact Preference: Patient Only Patient's Spouse Anyone answering phone

Referral Source: _____

Pharmacy Name: _____ Phone ( ) _____-_____

Pharmacy Address: _____

Your Co-Payment/Deductable is due today

Please Circle pay by: Check – Cash – Credit Card

Marion County Podiatry Specialists

1) What is the problem/condition you are having? _____

_____

2) Is your problem/condition a result of an injury? YES NO If Yes, is this work related? YES NO
Describe the injury: _____

How long have you been having this problem/condition? _____

3) As a result of your condition, what activities are you unable to perform at this time? _____

_____

4) Have you seen a physician for this condition? YES ☐ NO ☐ If YES, who and when? _____

5) Any prior treatments? _____

6) Are you Diabetic: YES NO If YES, Type I ☐ Type II ☐

Name of physician monitoring diabetes: _____

Last date seen by diabetes physician: _____

7) Do you experience any burning, numbness, tingling or weakness? YES ☐ NO ☐

If YES, where? _____

8) Do you experience any cramping? YES ☐ NO ☐

If YES, where? _____

9) Current Medications:

Name:	Dose:	Name:	Dose:

10) Allergies: _____

11) Surgical History: _____

_____

12) Prior Hospitalizations: _____

Name Of Primary Care Physician: _____ Phone ( ) _____

Shoe Size: _____

13) Do you have a PACEMAKER or DEFIBRILLAOR? YES ☐ NO ☐ If YES, when placed? _____

Patient Name: _____ Date: _____

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Do you have, or have had in the past, any of the following?

Fever/Chills	☐ Yes ☐ No	Burning/Tingling/Numbness	☐ Yes ☐ No
Hearing Loss	☐ Yes ☐ No	Blurred Vision	☐ Yes ☐ No
Frequent sore Throat	☐ Yes ☐ No	Infection	☐ Yes ☐ No
Ringing in Ears	☐ Yes ☐ No	Callous	☐ Yes ☐ No
Chest Pain	☐ Yes ☐ No	Wound	☐ Yes ☐ No
Foot/Ankle Swelling	☐ Yes ☐ No	Rash/Itching	☐ Yes ☐ No
Heart Valve Problems	☐ Yes ☐ No	Change in Mole	☐ Yes ☐ No
Diarrhea	☐ Yes ☐ No	Deformed Nails	☐ Yes ☐ No
Loss of Appetite	☐ Yes ☐ No	Balance Problems	☐ Yes ☐ No
Nausea/Vomiting	☐ Yes ☐ No	Headaches	☐ Yes ☐ No
Weight Gain/Loss	☐ Yes ☐ No	Joint Stiffness	☐ Yes ☐ No
Shortness of Breath	☐ Yes ☐ No	Joint Pain	☐ Yes ☐ No
Chronic Cough	☐ Yes ☐ No	Weakness	☐ Yes ☐ No
Menopausal	☐ Yes ☐ No	Fatigue	☐ Yes ☐ No
Gastrointestinal Ulcer	☐ Yes ☐ No	Frequent Urination	☐ Yes ☐ No
Gastroesophageal Reflux Disease	☐ Yes ☐ No	Stent Placement in Lower Extremity	☐ Yes ☐ No

Social History:

Do you use recreational Drugs? ☐ Yes ☐ No

Do you exercise routinely? ☐ Yes ☐ No

Do you intake caffeine? ☐ Yes ☐ No If yes, how much daily? _____

HIV/AIDS ☐ Yes ☐ No

Do you use Tobacco? ☐ Yes ☐ No ☐ Former If yes, how long? _____

If Former, how long ago did you quit? _____ How long did you use? _____

Type of Tobacco ☐ Pipe ☐ Cigar ☐ Cigarettes ☐ Chew

Amount: ☐ Less than one pack per day ☐ One pack per day ☐ More than one pack per day

Do you use Alcohol? ☐ Yes ☐ No ☐ Socially ☐ Daily # drinks per day: _____ # drinks per week: _____

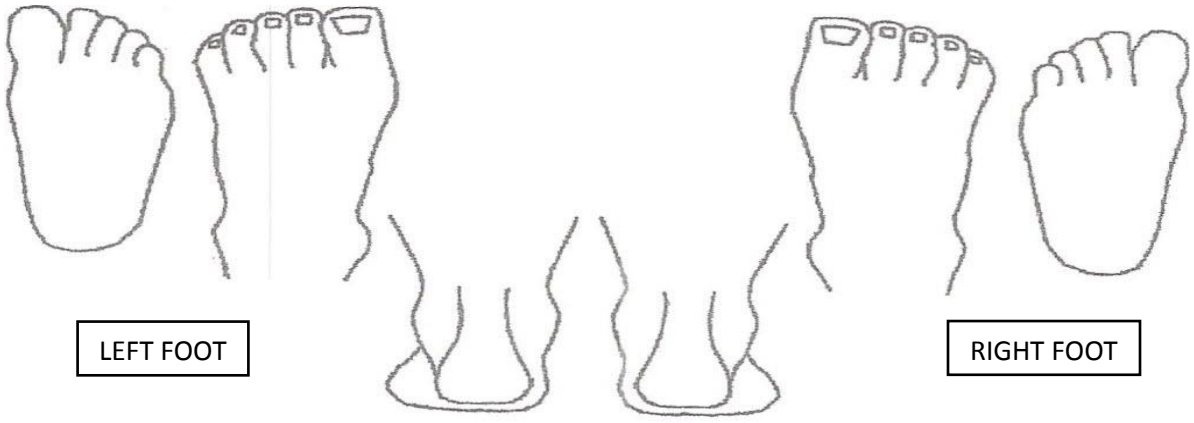
Family History:	Age	Diabetes	High B/P	Heart Disease	Stroke	Mental ILL.	Cancer
Mother ☐ Living ☐ Deceased	____	____	____	_____	____	____	____
Father ☐ Living ☐ Deceased	____	____	____	_____	____	____	____
Sibling ☐ Living ☐ Deceased	____	____	____	_____	____	____	____
Children ☐ Living ☐ Deceased	____	____	____	_____	____	____	____

Patient Name: _____ Date: _____

Marion County Podiatry Specialists

Past Medical History

Diabetic	☐ Yes	☐ No	Crohn's Disease	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Hiatal Hernia	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Colitis	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No	Cirrhosis	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Peripheral Vascular Disease	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Carpal Tunnel	☐ Yes	☐ No
Raynauds Syndrome	☐ Yes	☐ No	Neuropathy	☐ Yes	☐ No
Menieres Disease	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Dialysis	☐ Yes	☐ No	Pancreatitis	☐ Yes	☐ No
Phlebitis	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No
Venous Insufficiency	☐ Yes	☐ No	Hypercholesterolemia	☐ Yes	☐ No
Respiratory Disease	☐ Yes	☐ No	Osteomyelitis	☐ Yes	☐ No
Alzheimers Disease	☐ Yes	☐ No	Sciatica	☐ Yes	☐ No
Parkinsons Disease	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Fractures	☐ Yes	☐ No
Fibrmyalgia	☐ Yes	☐ No	Hip Replacement	☐ Yes	☐ No
RSD/CRPS	☐ Yes	☐ No	Knee Replacement	☐ Yes	☐ No
Hist. of Deep Vein Thrombosis	☐ Yes	☐ No	Hist. of Pulmonary Embolism	☐ Yes	☐ No



0 1 2 3 4 5 6 7 8 9 10

NO PAIN MODERATE PAIN WORST POSSIBLE

Current Pain Level: _____ Worst Pain Level: _____

Patient Name: _____ Date: _____

HIPPA NOTICE OF PRIVACY PRACTICES

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

LIFETIME AUTHORIZATION

INSURANC 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 concent for treatmet to all physicians associated with Carl M. Salvati, D.P.M.

VI. CONSENT TO DISCUSS MEDICAL CONDITION OR RELEASE RECORDS: I, the below named patient do authorize 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 Name _____ Date _____

SUBSCRIBER (if different from patient) Name: _____

Medical Records Request Form

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Carl M. Salvati, D.P.M.
812 NE 25th Ave., Suite A
Ocala, Fl 34470
Phone: (352) 351-4444 Fax: (352) 351-4920

Date: _____

Name: _____
D.O.B.:_____
Social Secutiry# _____

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: _____

To:
Carl M. Salvati, D.P.M.
Fax (352) 351-4920

Patient Signature: _____ Date: _____