SALAMA FOOT CARE

Dr. Mayer Salama • Dr. Daniel Salama • Dr. Brendan Johnson

WELCOME TO OUR OFFICE

NAME _____
LAST FIRST

ADDRESS _____
STREET APT# CITY STATE ZIP

HOME PHONE (_____) _____ CELL (_____) _____ WORK (_____) _____

AGE _____ BIRTHDATE _____ E-MAIL ADDRESS _____

SEX (circle) ○ M ○ F HEIGHT _____ WEIGHT _____ SHOE SIZE _____

YOUR OCCUPATION _____ EMPLOYER _____

EMPLOYER'S ADDRESS _____

NAME RELATIONSHIP PHONE

EMERGENCY CONTACT _____ (_____) _____

MARITAL STATUS (circle) ○ S ○ M ○ W ○ D NAME OF SPOUSE/PARTNER _____

DO YOU HAVE HEALTH INSURANCE? ☐ YES ☐ NO if yes, we'll need to copy your card(s).

IS IT YOUR POLICY? ☐ YES ☐ NO WHOSE POLICY IS IT? _____

GUARANTOR *(RESPONSIBLE PAR1Y FOR THIS ACCOUNT OR CUSTODIAL PARENT) complete if different than above*

NAME _____ (_____) _____
RELATIONSHIP PHONE

ADDRESS _____ GUARANTOR'S BIRTHDATE _____

GUARANTOR'S EMPLOYER _____ (_____) _____
NAME ADDRESS PHONE

- If you did not bring insurance cards with you, all charges will be your responsibility and payable at the time of service. Obtaining required referral forms and treatment pre-certification is the patient's responsibility.

All unpaid balances and/or denied claims are your responsibility.

NAME OF PRIMARY INSURANCE _____

NAME OF SECONDARY INSURANCE _____

NAME OF ADDITIONAL INSURANCE PLANS _____

PHYSICIAN'S NAME _____ PHONE(_____) _____ LAST VISIT _____

PREFERRED PHARMACY _____ PHONE/LOCATION _____

WHO REFERRED YOU TO OUR CARE? _____

- WHAT IS YOUR FOOT PROBLEM? _____
- FOR HOW LONG HAVE YOU HAD THE PROBLEM? _____ HAVE YOU BEEN TREATED FOR IT? ☐ YES ☐ NO

BY WHOM? _____

IS YOUR FOOT PROBLEM THE RESULT OF A WORK-RELATED INJURY? ☐ YES ☐ NO

Medical Information

Past Medical History

Have you ever had any of the fo1lowing?

- ☐ Measles
- ☐ Mumps
- ☐ Chickenpox
- ☐ Rheumatic Fever
- ☐ AIDS or HIV+
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Balance Problems
- ☐ Bladder Problems
- ☐ Blood/Plasma Transfusions
- ☐ Bowel Problems
- ☐ Cancer
- ☐ Cataract
- ☐ Cellulitis
- ☐ Circulatory Disorders
- ☐ COPD/Breathing
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ear/Nose/Throat Problems
- ☐ Epilepsy
- ☐ Fainting
- ☐ Fevers over 103°
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Hearing Loss
- ☐ Hepatitis _____
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Migraine Headaches
- ☐ Numbness/Tingling
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prolonged Bleeding
- ☐ Psychological Problems
- ☐ Seizure
- ☐ Sexually Transmitted Disease
- ☐ Skin Problems
- ☐ Stroke Problems
- ☐ Swelling of Feet/Ankles
- ☐ Tuberculosis
- ☐ Thyroid Disease
- ☐ Transplant
- ☐ Ulcer Stomach/Skin
- ☐ Varicose Veins
- ☐ Vision Problems
- ☐ Other _____

Previous Hospitalizations/Surgeries/Serious Illness (and When?) _____

_____

_____

What medications &/or vitamins are you taking now and what dose? _____

_____

_____

(Women) Are you pregnant? ☐ Yes ☐ No Are you taking Birth Control Pills? ☐ Yes ☐ No

Are you under the care of a physician? ☐ Yes ☐ No If yes, for what reason(s)? _____

Social History

Do you live alone? ☐ Yes ☐ No For how long? _____

Do you have children? ☐ Yes ☐ No If yes, how many? _____

Do you exercise? ☐ Yes ☐ No If yes, how often? _____ What kind of exercise? _____

Are you on a special diet? ☐ Yes ☐ No If yes, what kind? _____

Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? #_____ for #_____ years.

If former smoker, when did you quit? _____ How many packs had you smoked? # _____ per day for# ____ years.

Do you drink alcohol? ☐ Yes ☐ No How much _____ Daily _____ Weekly _____ Monthly _____ Yearly

Do you have a history of substance abuse? ☐ Yes ☐ No What substance(s)? _____

Medical Information

Family History

Has anyone in your family ever been diagnosed with the following? Name the relationship next to the condition in the space provided.

☐ Heart Disease ☐ Cancer ☐ Diabetes
☐ Circulatory Disease ☐ Hypertension ☐ Arthritis
☐ Neurological Problems ☐ Skin Disease ☐ Foot Problems

Additional space, if necessary _____

_____

Review of Systems

Please indicate any personal history below, circle:

• Constitutional Symptoms
Good general health lately ..... ☐ Yes ☐ No
Recent weight change ..... ☐ Yes ☐ No
Fever ..... ☐ Yes ☐ No
Fatigue ..... ☐ Yes ☐ No

• Eyes
Wear glasses/contact lenses..... ☐ Yes ☐ No
Blurred or double vision ..... ☐ Yes ☐ No

• Ears/Nose/Mouth/Throat
Hearing loss..... ☐ Yes ☐ No
Earaches..... ☐ Yes ☐ No
Ringing in ears..... ☐ Yes ☐ No
Sinus problem ..... ☐ Yes ☐ No
Nose bleeds ..... ☐ Yes ☐ No
Swollen glands in neck ..... ☐ Yes ☐ No

• Cardiovascular
Chest pain or angina..... ☐ Yes ☐ No
Swelling of feet, ankles or hands.. ☐ Yes ☐ No

• Respiratory
Chronic or frequent coughs.....☐ Yes ☐ No
Shortness of breath..... ☐ Yes ☐ No

• Gastrointestinal
Loss of appetite .....☐ Yes ☐ No
Nausea or vomiting.....☐ Yes ☐ No
Diarrhea .....☐ Yes ☐ No
Constipation .....☐ Yes ☐ No
Blood in stool .....☐ Yes ☐ No
Abdominal pain .....☐ Yes ☐ No

• Genitourinary
Frequent urination .....☐ Yes ☐ No
Burning or painful urination..... ☐ Yes ☐ No
Blood in urine..... ☐ Yes ☐ No
Incontinence or dribbling ..... ☐ Yes ☐ No

• Musculoskeletal
Joint pain ..... ☐ Yes ☐ No
Joint stiffness or swelling ..... ☐ Yes ☐ No
Muscle pain or cramps ..... ☐ Yes ☐ No
Back pain ..... ☐ Yes ☐ No
Cold extremities..... ☐ Yes ☐ No
Difficulty in walking..... ☐ Yes ☐ No

• Integumentary (skin, breast)
Rash or itching ..... ☐ Yes ☐ No
Change in skin color ..... ☐ Yes ☐ No
Change in hair or nails..... ☐ Yes ☐ No

• Neurological
Headaches..... ☐ Yes ☐ No
Lightheaded or dizzy..... ☐ Yes ☐ No
Convulsions or seizures..... ☐ Yes ☐ No
Numbness or tingling sensations.. ☐ Yes ☐ No
Tremors .....☐ Yes ☐ No
Paralysis or weakness ..... ☐ Yes ☐ No

• Psychiatric
Memory loss or confusion..... ☐ Yes ☐ No
Nervousness ..... ☐ Yes ☐ No
Depression ..... ☐ Yes ☐ No
Insomnia ..... ☐ Yes ☐ No

• Endocrine
Excessive thirst or urination ..... ☐ Yes ☐ No
Heat or cold intolerance ..... ☐ Yes ☐ No
Skin becoming drier..... ☐ Yes ☐ No

• Hematologic/Lymphatic
Slow to heal after cuts ..... ☐ Yes ☐ No
Bleeding or bruising tendency . ☐ Yes ☐ No
Phlebitis..... ☐ Yes ☐ No
Past transfusion ..... ☐ Yes ☐ No

Allergies

Do you have a history of skin reaction or other adverse reaction to:

☐ Anesthetics ☐ Codeine ☐ IV Dye ☐ Silver
☐ Animals/Dander ☐ Environmental ☐ Pain Medication ☐ Sulfa
☐ Antibiotics ☐ Substances Foods ☐ Penicillin Seasonal ☐ Tape
☐ Aspirin ☐ Iodine ☐ Allergies ☐ Tetanus

Specify above and list any others: _____

To the best of my knowledge, the above information that I have submitted is correct. I understand that giving incorrect information can be dangerous to my health. It is my responsibility to inform the doctors' office of any changes in my medical status. I, hereby, give my permission to the Doctors of SALAMA FOOT CARE to diagnose and administer treatment of my foot condition.

Signature_____ Date _____ Reviewed by:_____

SALAMA FOOT CARE

PATIENT AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR TREATMENT. I hereby consent to the treatment provided by SALAMA FOOT CARE and its employees or designees. I authorize the physical health care services deemed necessary or advisable by my caregivers to address my needs. _____
(initial)

CONSENT FOR PHOTOGRAPHS. I grant permission for photographs to be taken to assist in documenting my condition. _____
(initial)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION.
I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment *to* me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of the Practice. I authorize the Practice to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that the Practice may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. _____
(initial)

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/COLLECTION FEE.
I authorize payment to be made directly to the Practice for insurance benefits payable to me. I understand that I am financially responsible to the Practice for any covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorney's fees.

_____
(initial)

PRIVACY POLICY. I acknowledge having received the Practice's "Notice of Privacy Policies". My rights including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, is explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent the Practice has already made disclosures with my prior consent. _____
(initial)

CANCELLATION POLICY. I understand that if I am unable to keep an appointment, I must give at least a 24 hour notice so that another patient might be able to use my reserved time. In the event that I don't give advance notice, I will incur a "no show" or "last minute" cancellation fee of $95. _____
(initial)

_____ _____ _____
Patient or Authorized Person Signature Relationship Date