Salcedo PODIATRY
Relief From Painful Feet

Active feet are happy feet.

William Salcedo, D.P.M.
Diplomat American Board of Podiatric Surgery
Board Certified in Foot Surgery
Se Habla Español

New Patient Information Form

(Please Print)

Date:____/____/____ Patient Name:_____ _____ _____
Last First MI

Social Security #:_____ Date of Birth:____/____/____ Age:_____ Sex: M ☐ | F ☐

Primary Address:_____ City/State:_____ Zip:_____

Secondary Address:_____ City/State:_____ Zip:_____

Primary Phone #:(_____) _____ - _____ Secondary Phone #:(_____) _____ - _____

E-mail: _____ Primary Language: _____

Race: White ☐ | American Indian or Alaska Native ☐ | Asian ☐ | Black or African American ☐ | Native Hawaiian or Pacific Islander ☐

Ethnicity: Hispanic or Latino ☐ | Non-Hispanic or Non-Latino ☐

Do you have a legal guardian or healthcare power of attorney? Yes ☐ | No ☐

If yes, Name: _____ Relationship:_____

Cell Phone #:(_____) _____ - _____

Emergency Contact: _____ Relationship:_____

Cell Phone #:(_____) _____ - _____

Primary Care Doctor: _____

Who referred you to us? Physician ☐ | Friend ☐ | Family ☐ | AT&T YP ☐ | Insurance ☐ | Online YP ☐ | Website ☐

Pharmacy: _____ Address: _____ (_____) _____ - _____

Is there a family member or other person you would like for us to share your medical information?

☐Yes Name (s) _____ ☐No

Are you a student? Yes ☐ | No ☐ If yes, full time ☐ or part time ☐

Are you employed? Yes ☐ | No ☐ If yes, full time ☐ or part time ☐

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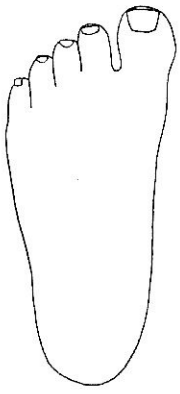
Current Problem

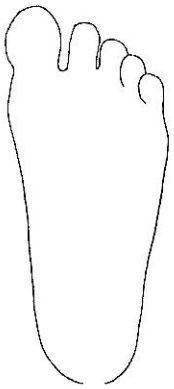
What specific problem brings you to our office today?_____

Where is the pain/problem located? (please mark with pen or pencil on the pictures below)

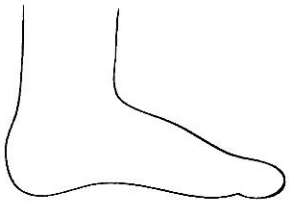
Left Foot

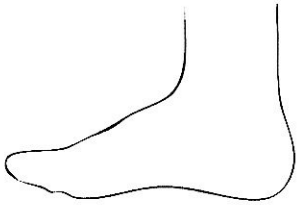


Top of Foot

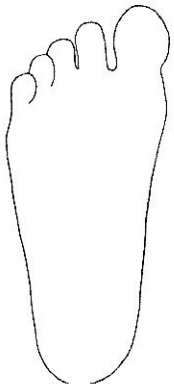


Bottom of Foot

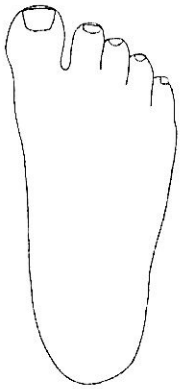




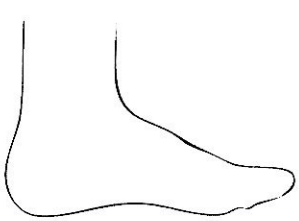
Right Foot

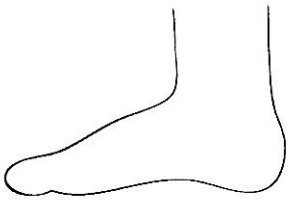


Bottom of Foot



Top of Foot





How long ago did this problem first start?_____ Days ☐ | Weeks ☐ | Months ☐ | Years ☐

Did your pain or problem: Begin all of the sudden ☐ | Develop over time ☐

How would you describe your pain? No Pain ☐ | Sharp ☐ | Dull ☐ | Aching ☐ | Burning ☐ | Radiating ☐ | Itching ☐ | Stabbing ☐

Other ☐ _____

How would you rate your pain on a scale from 0 to 10? (no pain) 0☐ | 1☐ | 2☐ | 3☐ | 4☐ | 5☐ | 6☐ | 7☐ | 8☐ | 9☐ | 10☐ (worst pain)

Since the time your pain or problem began, has it: Stayed the same ☐ | Become worse ☐ | Improved ☐

What makes your pain or problem feel worse? Walking ☐ | Standing ☐ | Daily Activities ☐ | Resting ☐ | Dress Shoes ☐

High heels ☐ | Flat shoes ☐ | Any closed toe shoe ☐ | Running ☐ | Other ☐ _____

What makes your pain or problem feel better?_____

What treatments have you had for this problem?_____

How was this problem affected your lifestyle or ability to work?_____

Was this problem caused by an injury? Yes ☐ (describe) _____ | No ☐

If yes, was it a work-related injury? Yes ☐ | No ☐

Have you ever been treated by a podiatrist? Yes ☐ | No ☐ What for?_____

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Please list all medications you are currently taking (include prescriptions, over-the-counter meds and herbal supplements):
If you brought a list to this appointment, please hand it in when all paperwork is complete and you will not be required to complete this section

Name: Dose:

Please list all prior foot surgeries:

Type of Surgery Dat:

Social History

Marital Status: Single ☐ | Married ☐ | Partnered ☐ | Separated ☐ | Divorced ☐ | Widowed ☐

Use of Alcohol: Never ☐ | No Longer Use ☐ | History of Alcohol Abuse ☐ | Current Use - Type ☐ _____
Rare ☐ | Occasional ☐ | Moderate ☐ | Daily ☐

Use of Tobacco: Never ☐ | Quit ☐ How long ago?_____ | Smoke_____ Packs/Day for_____ years ☐

(All patients 13 years and older are legally required to answer.)

Does anyone in the family smoke? Yes ☐ | No ☐ If Yes, who?_____

Use of Recreational Drugs: Never ☐ | Quit ☐ How long ago?_____ Type _____
Current Use ☐ Type _____ | Rare ☐ | Occasional ☐ | Moderate ☐ | Daily ☐

How much are you on your feet at work? 10% ☐ | 25% ☐ | 50% ☐ | 75% ☐ | 100% ☐

Do others depend upon you for their care? Children ☐ Age(s) _____ | Pets ☐ What kind?_____
Elderly or disabled family member ☐ | Other ☐ _____

Exercise: Never ☐ | Rare ☐ | Occasional ☐ | Weekly ☐ | Several times a week ☐ | Daily ☐
Types of exercise: _____

Family History

Do you have a family history of: Diabetes ☐ | Cancer ☐ | Heart Disease ☐ | High Blood Pressure ☐ | Stroke ☐

Coronary Artery Disease ☐ | Thyroid Disease ☐ | Rheumatoid Arthritis ☐ | Other ☐ _____

Your Medical History

Allergies: None Known ☐ | Medications ☐ _____

Anesthesia ☐ _____ | Foods ☐ _____

Tape ☐ | Latex ☐ | Shellfish ☐ | Iodine ☐ | Other ☐ _____

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Have you ever had any of the following? (Please only check the ones that apply)

	✓
Atrial Fibrillation	
Acid Reflux	
Anemia	
Arthritis	
Rheumatoid	
Osteo	
Asthma	
Back Trouble	
Bladder Infections	
Abnormal Bleeding	
Blood Clots	
Blood Transfusion	
Bronchitis/Emphysema	
CABG	
Cancer	
Chest Pain	
Diabetes	
Insulin Dependent	
Non-Insulin Dependent	

	✓
Fibromyalgia	
Gout	
Heart Attack	
Heart Disease/Failure	
Hepatitis	
HIV +/Aids	
High Blood Pressure	
High Cholesterol	
High Lipids	
Kidney Disease	
Dialysis	
Liver Disease	
Low Blood Pressure	
Low Back Pain	
Migraine Headaches	
Mitral Valve Prolapse	
Neuropathy	
Other:	

	✓
Open Sores	
Osteoporosis	
Pacemaker	
Pneumonia	
Polio	
Rheumatic Fever	
Shortness of Breath	
Sickle Cell Disease	
Skin Disorder	
Sleep Apnea	
Stomach Ulcers	
Stroke	
Thyroid Disease	
TIA	
Tuberculosis	
Valve Disease	
Other:	

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the Doctor and office staff of any changes in my medical status. I give my permission for Dr. William Salcedo to administer treatment as may be deemed necessary in the diagnosis and/or treatment of my foot/ankle condition.

Print name of patient, parent or guardian

Signature of Doctor

If other than patient, relationship to patient

Date

Signature

Date

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Patient Consent for Use and Disclosure of Protected Health Information

PATIENT NAME: _____

I hereby give my consent for William Salcedo, DPM, PA to use and disclose protected health information (PHI) to carry out treatment, payment, and health care operations (TPO). This information may be mailed, faxed or e-mailed electronically through a HIPAA protected portal. In order to receive protected communication and access to my electronic medical records, I must provide my e-mail address to this office. I may send and receive e-mails through a HIPAA protected e-mail portal or through IQ health, our patient portal. William Salcedo, D.P.M., PA's Notice of Patient Privacy Practices provides a more complete description of such uses and disclosures and is available upon request.

With this consent, I understand that William Salcedo, D.P.M., P.A. employees may call my home phone, cell phone, leave a voice mail on either phone, send an e-mail, or communicate via a patient portal to confirm an appointment 1-2 days prior to that appointment. Employees may also communicate in the same methods in reference to any items that assist the practice in carrying out TPO, handling insurance issues, and communication about my clinical care; this would include lab results among other items.

Patient statements may be mailed to my home or other location and will be marked Personal and Confidential.

William Salcedo, DPM, PA will send a thank you note as well as a copy of the initial office visit note to the referring physician.

By signing this form, I am consenting to William Salcedo, DPM, PA's use and disclosure of my PHI to carry out TPO.

I know that I may request a copy of William Salcedo, DPM, PA's Privacy Practices.

_____ _____

Print name of patient, parent or guardian Signature

_____

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Financial Policy

PATIENT NAME: _____

I understand the following:

William Salcedo, DPM, PA is a participating provider for most insurance companies allowing me to receive the greatest financial discount available through my particular insurance company. My insurance benefits will be verified in order to accurately determine my financial responsibility; co-payments, deductibles, and co-insurance are always due at the time of service. The amount collected is an estimate of what will be due, and so I may receive an invoice for the balance after the claims are processed. This office submits all claims to my insurance company (s). I understand that payment is due upon receipt.

If I become a surgical patient, I will be responsible for paying co-payments, deductibles, and co-insurance at my pre-op consent appointment.

If my address changes, I will update it with William Salcedo, DPM, PA's office. I understand that payment is due within 15 days of invoice mailings. I have been notified that accounts may be sent to collections if balances are not paid within 45 days of the initial invoice mailings. If I am sent to collections because I am delinquent in paying my balance, I will be responsible for collection costs in addition to the outstanding balance; I understand that collection costs are approximately 30% of the original balance.

If I ever have a question about a claim, I will call Janice at 772-337-0014.

Responsible Party Information

Name:	Spouse's Name:
DOB:	Spouse's DOB:
Cell Phone:	Spouse's Cell Phone:
SS#:	Spouse's SS#:
Employer:	Spouse's Employer:
Employer Phone #:	Spouse's Employer's Phone#:
Address:	

_____ _____

Print name of patient, parent or guardian Signature

_____

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Assignment of Benefits

Patient Name:_____Date of Birth:_____

I authorize the release of any medical or other information necessary to process my insurance claims. I also authorize payment of insurance medical benefits from the government or private insurance companies to William Salcedo, DPM, PA for services rendered. I am authorizing this signed form to be kept on file and for copies of this form to be used in place of the original. This authorization is to apply to all claims filed on my behalf that are sent to my current insurance companies or those that I may have in the future.

_____ _____

Print name of patient, parent or guardian Signature

_____ _____

If other than patient, relationship to patient Signature

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