

DR. MICHAEL SALCEDO
53779 Generations Dr., Ste. D
South Bend, IN 46635
574-271-1030

Acct # _____

===== **PATIENT INFORMATION** =====

Name: _____ Title: Mr./Mrs./Other _____ Suffix: Jr./Sr./Other _____
Last First M.I.

Address: _____
City State Zip

Home ph: _____ Work ph: _____ Cell ph: _____ E-mail: _____

Social Security # _____ Date of Birth: _____ Gender: M or F

Employment Status: Full time Part time Self Employed
(circle one) Not employed Retired Active Military
Employer: _____
Emp. Address: _____

Marital Status: Married Single Widowed Divorced
Student: Full or Part Time (circle one)

Family Physician: _____

Is this an accident or Injury? Y or N Date of Injury: _____

Work Related? Y or N Date symptoms began: _____

Work Related must have authorization from employer

Emergency Contact Name: _____ Relationship: _____

Phone: Home _____ Work _____ Cell _____

===== **RESPONSIBLE PARTY INFORMATION** =====

IF OTHER THAN PATIENT, SEND STATEMENT/BILL TO:

Responsible Party _____ Title: Mr./Mrs./Other _____ Suffix Jr./Sr./Other _____
Last First M.I.

Mailing Address: _____
City State Zip

Phone: Home _____ Work _____ Cell _____

Social Security # _____ Date of Birth _____ Gender: M or F

Employment Status: Full time Part time Self Employed
(circle one) Not employed Retired Active Military
Employer: _____
Relationship to Patient: _____

===== **INSURANCE INFORMATION** =====

Scan/Copy Card

PRIMARY: _____ **SECONDARY:** _____

Policy # _____ Grp# _____ Policy # _____ Grp# _____

Insured _____ DOB _____ Insured _____ DOB _____

Relationship to Patient _____ Relationship to Patient _____

By signing this, I hereby acknowledge Dr. Michael Salcedo has the right to use and disclose Protected Health Information (PHI) for treatment, payment and health care operations, and that I have received the *Notice of Privacy Practices*. I understand I have the right to restrict how PHI is used or disclosed, and that Dr. Michael Salcedo is not required to agree to any restriction, but if an agreement is reached, Dr. Michael Salcedo is bound by the agreement.

Signature

Date

DR. MICHAEL SALCEDO
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I hereby authorize Dr. Michael Salcedo (and the doctor's assistants or designated replacements) to evaluate, recommend, administer and perform such procedures upon me as the doctor deems necessary. I understand I have the right to refuse any such recommendations/treatments.

Signature

Date

I verify the above information is true and accurate as of the below indicated date. I hereby authorize my insurance company to pay directly to Dr. Michael Salcedo benefits due on my behalf, if any, as provided in the above unexpired policy. I understand that the responsible party listed is held accountable for charges **not** covered by Medicare, Medicaid or Private Insurance. I will pay all charges in excess of whatever sums may be allowed by my insurance. If payment arrangements are not made, I acknowledge outstanding amounts due from me greater than 60 days will be turned over to a collection agency and a \$25 fee will be added to my outstanding balance.

Signature

Date

OFFICE POLICIES:

INSURANCE: Prior to being seen, please obtain an insurance referral through your primary care physician if one is required. Also please verify through your insurance company whether Dr. Michael Salcedo is in-network in order for claims to be paid at the highest benefit level.

ARRIVING MORE THAN 15 MINUTES LATE: You will be asked to reschedule your appointment.

MEDICAL RECORD COPYING: In accordance with Indiana's IAC Rule 760 1-71-3, we charge a \$20 labor fee for the first ten pages of medical records being copied. For additional pages, there is \$.50 charge per page for pages eleven through fifty, and a \$.25 fee per page for pages fifty-one and higher. When records are transferred doctor to doctor for continuity of care, no charge applies.

RETURNED CHECK (NSF): A \$30 fee will be added to your account for all returned checks.

COPAY: Applicable co-pays are collected **PRIOR** to being seen by Dr. Michael Salcedo.

I acknowledge that I have read and understand the above office policies:

Signature

Date

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Acct# _____ Patient Name _____ Age _____

Chief Complaint: _____

Allergies: None
 Adhesive/Tape Aspirin
 Penicillin Anesthesia
 Sulfa Iodine
 Codeine Environmental
Other _____

Medications: _____

Pharmacy Name: _____
Phone number: _____

Tobacco Use: _____ **Alcohol Use:** _____ **Drug Use:** _____

Active medical problems: _____

Indicate which of the following problems you have had:

- | | | |
|--|--|--|
| General:
<input type="checkbox"/> Unexplained weight loss
<input type="checkbox"/> Fever
<input type="checkbox"/> Chills
<input type="checkbox"/> Nausea
<input type="checkbox"/> Cancer
<input type="checkbox"/> Anemia
<input type="checkbox"/> Clotting Disorder | Head:
<input type="checkbox"/> Ears
<input type="checkbox"/> Eyes
<input type="checkbox"/> Nose/Sinus
<input type="checkbox"/> Throat
<input type="checkbox"/> Headaches
<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Balance problems | Lungs:
<input type="checkbox"/> Respiratory diseases
<input type="checkbox"/> Asthma
<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Oxygen therapy
<input type="checkbox"/> Pulmonary disease
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> COPD
<input type="checkbox"/> Pulmonary disease |
| Cardiovascular:
<input type="checkbox"/> Hypertension
<input type="checkbox"/> Swelling in legs
<input type="checkbox"/> Circulation problems
<input type="checkbox"/> Chest pain
<input type="checkbox"/> Previous heart attack
<input type="checkbox"/> Cardiac Angioplasty
<input type="checkbox"/> Circulation problems
<input type="checkbox"/> Artificial heart valves
<input type="checkbox"/> Heart murmur
<input type="checkbox"/> Low blood pressure
<input type="checkbox"/> Phlebitis
<input type="checkbox"/> Blood clots
<input type="checkbox"/> Stroke
<input type="checkbox"/> Anemia
<input type="checkbox"/> Varicose Veins | Foot and leg:
<input type="checkbox"/> Fracture
<input type="checkbox"/> Heel pain
<input type="checkbox"/> Ankle pain
<input type="checkbox"/> Bunion
<input type="checkbox"/> Hammertoe
<input type="checkbox"/> Nail problem
<input type="checkbox"/> Calluses
<input type="checkbox"/> Corns
Other _____ | GI:
<input type="checkbox"/> Peptic ulcer
<input type="checkbox"/> Gastric Bypass
<input type="checkbox"/> Chronic diarrhea
<input type="checkbox"/> Liver disease
<input type="checkbox"/> Hepatitis |
| | Musculoskeletal:
<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Lupus
<input type="checkbox"/> Connective tissue disease
<input type="checkbox"/> Joint replacement
<input type="checkbox"/> Joint pain | Endocrine:
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Hormone imbalance |
| | | GU:
<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Dialysis
<input type="checkbox"/> Bladder incontinence |

Procedures or surgeries you have had: _____

I understand the above medical information is necessary to provide me with medical care in safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the office any change in my health or medication.

Patient/Guardian Signature: _____ Date: _____

Vital Signs: Height: _____ Weight: _____ BP: _____ Pulse: _____ Temp: _____