Dr. Mayer Salama, DPM
Dr. Daniel Salama, DPM

First Name_____ Last Name_____ F / M (circle)

Date of Birth_____ Age___ Social Security #_____

Home Address_____ City_____ State MI Zip_____

Phone # (H)_____ (C)_____ (W)_____

E-mail address:_____

Preferred form of communication: (circle) phone home - cell - work / e-mail / mail

Preferred Language:_____

Patient Employer:_____

Subscriber of Insurance:_____ Relation to patient:_____

Subscriber date of birth:_____ Subscriber Employer:_____

Emergency Name:_____ Relation to patient:_____

Emergency Number:_____

PCP Name:_____ PCP # _____

Pharmacy Name and Number:_____

Referred to us by:_____

** CMS (medicare / medicaid) requires providers to report both race and ethnicity

RACE (circle one) American Indian / Alaskan Native / Asian / Black or African American White or Caucasian / Native Hawaiian or Pacific Islander / Other / Decline to answer

ETHNICITY (circle one) Hispanic or Latino / Not Hispanic or Latino / Decline to answer

I understand the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers whom may be involved in that treatment directly and indirectly.
- Obtain payment from a third party payer.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

Signature and date_____

I have read and understand your *Notice of privacy practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has a right to change its notice of privacy practices form time to time and that I may contact this organization at any time to obtain a current copy of this notice. I understand that I may request in writing restrictions on how my private information is used and or disclosed to carry out treatment and or payment of health care options. I understand it is my responsibility to know my insurance coverage and if I have an HMO it is my responsibility to obtain prior authorization for visits and treatment.

I the Patient, parent or legal guardian, hereby authorize the physicians and staff of Dearborn Foot Specialists to give the following information concerning my health and well being:
_Appointment times _Test Results _Medications _Procedure Info. _Any other Information
_ I do not authorize the release of any medical information .
To be released to _ spouse _ Significant other _ Any specified named party
Names and relation:_____
If delay in treatment results because we can not relay information to another person, Dearborn Foot Specialists will not be held responsible.

SIGNATURE:_____ dATE:_____
Relationship to Patient:_____

_____

Chart Number _____ Date_____ Confirmed Via _____
Deductible:

Co Pay:

Specialist OV:

Name _____ Date_____

Last physical exam date_____Are you currently under the care of a physician? Y / N

Last PCP visit_____ TX for _____

Do you have any of the following? (please circle)

Rheumatic Fever	Rheumatic Heart Disease	Congenital heart lesions
Cardiovascular Disease	Chest pain upon exertion	Shortness of breath
Ankles swell	Sinus trouble.	Asthma
Hay fever	Hives	Skin rashes
Fainting	Seizures	Diabetes
Frequent urination	Dry mouth	Hepatitis
Jaundice	Liver disease	Arthritis
Inflammatory rheum	Stomach ulcers	Kidney trouble
Tuberculosis	Persistent cough	Low blood pressure
Abnormal bleeding	Bruise easily	Blood transfusion
Blood disorder	Tumor	Allergies

Allergies to (please check)

___Local anesthetics	___Penicillin	___Antibiotics	___Sulfa Drugs
___Barbituates	___Sedatives	___Sleeping pills	___Aspirin
___Iodine	___Codeine	___Narcotics	___Other

Current medications, dosage, and frequency (please list or provide copy)

_____

_____

_____

_____

If you are taking any of the following medications, please check

___Antibiotics	___Sulfa drugs	___Anticoagulants	___Blood pressure medication
___Cortisone	___Tranquilizers	___Antihistamines	___Aspirin
___Insulin	___Tolbutamine	___Digitalis	___Nitroglycerin

Smoking status: (circle one and provide quantity)

Every day smoker_____ Former smoker (quit date)_____

Occasional smoker_____ Never smoked_____

Do you have any disease or condition not listed above that I should know about? _____

Explain:_____

Women: Are you pregnant? Y / N

Height_____ Weight_____ Blood pressure _____/_____ = BMI_____

Signature:_____Date:_____