Acct #_____

DR. MICHAEL SALCEDO

3665 Park Place West, Ste 200

Mishawaka, IN 46545-3566

574-271-1030

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

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

Address:_____ _____
City State Zip

Home ph:_____ Cell ph:_____E-mail:_____

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

Race_____ Preferred Language Spoken_____

Family Physician:_____

Employer:_____ Emp Ph #_____

Emp. Address:_____

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

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

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 that 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 though 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. If an electronic copy of your health information is preferred, please specify this and we will fulfill your request within 3 business days.

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

DR. MICHAEL SALCEDO
3665 Park Place West, Ste 200
Mishawaka, IN 46545-3566
574-271-1030

Acct#_____ Patient Name_____ Age_____

Chief Complaint: _____

Allergies: __ None
__Adhesive/Tape __Aspirin
__Penicillin __Anesthesia
__Sulfa __Iodine
__Codeine __Environmental
Other_____

Medications: _____
_____
_____
_____
_____
_____
_____

Pharmacy Name: _____

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

Indicate which of the following problems you have had:

General:
__ Unexplained weight loss
__Fever
__Chills
__Nausea
__Cancer
__Anemia
__Clotting Disorder

Cardiovascular:
__Hypertension
__Swelling in legs
__Circulation problems
__Chest pain
__Previous heart attack
__Cardiac Angioplasty
__Circulation problems
__Artificial heart valves
__Heart murmur
__Low blood pressure
__Phlebitis
__Blood clots
__Stroke
__Anemia
__Varicose Veins

Head:
__Ears
__Eyes
__Nose/Sinus
__Throat
__Headaches
__Seizure disorder
__Balance problems

Foot and leg:
__Fracture
__Heel pain
__Ankle pain
__Bunion
__Hammertoe
__Nail problem
__Calluses
__Corns
Other_____

Musculoskeletal:
__Osteoarthritis
__Rheumatoid Arthritis
__Lupus
__Connective tissue disease
__Joint replacement
__Joint pain

Lungs:
__Respiratory diseases
__Asthma
__Shortness of Breath
__Oxygen therapy
__Pulmonary disease
__Tuberculosis
__COPD
__Pulmonary disease

GI:
__Peptic ulcer
__Gastric Bypass
__Chronic diarrhea
__Liver disease
__Hepatitis

Endocrine:
__Diabetes
__Thyroid disease
__Hormone imbalance

GU:
__Kidney disease
__Dialysis
__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: _____