Adirondack Foot Care
Salvatore J. Galluzzo, D.P.M/Douglas Mason D.P.M

950 Route 146, Clifton Park, NY 12065
158 Saratoga Avenue Waterford, NY 12188

PLEASE PRINT

Patient: ______________________ S.S. #: ______________________ Date of Birth: ______________

Address: ______________________________________ Home Phone #: ( ) ______________
(Number & Street)

______________________________________ Marital Status: __________ Sex: ☐ Male ☐ Female
(Town) (State) (Zip)

Employer: ______________________________________ Work Phone #: ( ) ______________

Address: ____
(Number & Street) (Town) (State) (Zip)

Next of Kin: ______________________ Relationship: ______________ Phone #: ( ) ____________

Address: ____
(Number & Street) (Town) (State) (Zip)

Who is responsible for payment of this bill? ☐ **Patient** ☐ **Other** ______________________

Name of Responsible Party: ______________________________ Relationship: ______________

Address: ______________________________ Date of Birth: ______________

A copy of your insurance card and identification is required at time of appointment

Who is your Primary Physician?: ______________________________ **Date of Last Examination** ____/____/____

What Pharmacy do you use? ______________________________ **Phone Number** ______________

How did you find out about our practice?:

____

What Foot Problem Brings You to Our Office: ____

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Assignment and Release: I hereby authorize my insurance benefits to be paid directly to Dr. Salvatore Galluzzo and acknowledge that **I am ultimately financially responsible for all charges and/or balances whether or not covered by insurance** and in the event of not payment I am responsible costs of recovery and/or collection. I also authorize the physician to release any information required to my insurance carrier(s).

Signed: ______________________________________ Date: ______________________

In the event of non-payment you may be responsible for reasonable costs of recovery & collection.

Revised-1/2014

Adirondack Foot Care

Patient's Medical History & Chief Complaint **Dr. Salvatore J. Galluzzo,DPM Dr. Douglas E. Mason,DPM**

Patient Name: ___________________________________ D.O.B.: ___________ Sex: M F Date of Treatment: ___________

Chief Concern: ____

____

____ Onset of Condition / Duration: ______________________

Family History

	Father	**Mother**	**Brothers / Sisters**	**Children**
Diabetes				
High / Low Blood Pressure				
Heart Disease				
Stroke				
Cancer				
Gout				
Arthritis				
Asthma / Emphysema				
Kidney / Liver Disease				
Colitis				
Ulcers				
State of Health if Living				
Cause of Death				

Personal Social History

Do you use tobacco?	Yes	No
Avg # of packs / day		
Number of years		
Do you consume alcoholic beverages?		
Yes	No	Social
Do you use drugs (recreational)?		
Yes	No	
Do you exercise regularly?		
Yes	No	

Personal Medical History – Have you ever had or been diagnosed with:

	Yes	**No**
High / Low Blood Pressure		
Heart Disease		
Heart Murmur		
Stroke		
Heart attack		
Enlarged Heart		
Seizures		
Bleeding Disorder		
Blood Transfusion		
Anemia		
Pneumonia		
Emphysema		
Asthma		
Hay Fever		

	Yes	**No**
Eye Trouble		
Cataracts		
Glaucoma		
Diabetes		
Gout		
Thyroid Disease		
Kidney / Liver Disease		
Urinary Tract Infection		
Jaundice		
Gall Bladder Disease		
Ulcers		
Colitis		
Diverticulitis		
Unconsciousness		

	Yes	**No**
Cancer		
Skin Cancer		
Radiation Treatment		
Breast Lump		
Rheumatic Fever		
Elevated Cholesterol		
Measles		
Rubella (German Measles)		
Mumps		
Venereal Disease		
Exposure to TB		
Broken Bones		
HIV Positive		

Drug Sensitivities: ____

____

Previous Operations: ____

Current Medications:

Signature: Date

(for Doctor's use only)

Initial Physical Examination & Findings

Patient: ____

Muscle Groups	**Mass**	**R**	**L**	**Strength**	**R**	**L**		**Vascular**	**R**	**L**
Anterior				Anterior	/5	/5		Femoral	/4	/4
Posterior				Posterior	/5	/5		Popliteal	/4	/4
Lateral				Lateral	/5	/5		PT	/4	/4
Intrinsic				Intrinsic	/5	/5		DP	/4	/4
Capillary Return		Varicosities			Color			Temperature		

Neurological			
Babinki Reflex	DTR	VIB	Sharp / Dull

Orthopedic Evaluation															
	R	**L**			**R-1**	**2**	**3**	**4**	**5**		**L-1**	**2**	**3**	**4**	**5**
HAV (Bunion)				**Hammertoe**											
Tailor's Bunion				PIPJ											
Pronation				DIPJ											
Cavus Type															
Planus Type				**Amputation**											

X-Rays	**View**	**Ankle**		**Foot**		**Toes**		**Dermatological**	
	AP	R	L	R	L	R	L	Skin	Nails
	LAT	R	L	R	L	R	L	Fissures	
	MO	R	L	R	L	R	L	Lesions	Ulcers
Other									

Diagnosis: ____

____

Plan: ____

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____

____

____

____

____

____

Podiatrist's Signature: ______________________________________ Date: ________________

Adirondack Foot Care

950 Route 146
Clifton Park, NY 12065

Phone (518) 383 - 0302
Fax (518) 373 - 2298

Our practice has implemented the following policy which will allow you to reschedule your procedure or office visit no more than three times before we ask that you seek care elsewhere and we will notify your referring physician of such. Although we do understand that sometimes situations arise beyond your control, if you find it necessary to change your appointment more than three times you will be asked to return to your primary care physician to seek care. We find this is necessary due to the increase in rescheduling and no-shows that have occurred. As a result we are finding it difficult to provide optimal care to all our patients.

Therefore, we adopted the following policies associated with last minute cancellations and no-shows. The following fees will be incurred.

Less than 48 hours' notice of cancellation for an office visit:	$ 50.00
Short Notice (Less than 24 hours) cancellation for an office visit:	$100.00
Less that 5 days notice of cancellation for surgery:	$ 100.00
Not showing for a scheduled office visit appointment:	$ 100.00
Not showing for a scheduled surgical procedure:	$ 100.00

This allows us adequate time to contact other patients eager to complete treatment.

Surcharge for non-payment of co-pay at time of service rendered:	$ 20.00
Returned check:	$ 25.00

Any of the fees above that have been placed on your account must be paid in full prior to any future appointments.

If you have any questions please see any staff member who will then direct you to the appropriate person if necessary.

We feel these fees are fair not only for us as a provider, but to you as a patient.

We thank you for your cooperation and allowing us to participate in providing you with quality health care.

Please sign below acknowledging the above policies.

____ __________________

Patient Signature Date

Adirondack Foot Care
Salvatore J. Galluzzo, DPM

950 Route 146
Clifton Park, NY 12065
(518) 383 – 0302

158 Saratoga Avennue
Waterford, NY 12118
(518) 237 – 3668

Acknowledge of Receipt of Notice of Privacy Practice and Consent to Use and Disclose Information for Treatment, Payment and Operational Purposes

By signing below, I hereby acknowledge that I have been provided with a copy of this office's *Notice of Privacy Practices* and have been advised of how my health information is protected and may be used and disclosed by this office and how I may obtain access to and control of this information. In addition, by signing below I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of the office.

___

Signature of Patient or Personal Representative

___

Print Name of Patient or Personal Representative

___

Relationship to or Legal Authority of Personal Representative

___

Date