"We keep you walking, We keep you healthy"

PODIATRY SERVICES OF ITHACA

VICTOR VILLAGONZALO, DPM
PODIATRIST
2255 N. TRIPHAMMER RD, ITHACA NY 14850
Tel: **(607) 257-8877** Fax: **(607) 257-8879**

PATIENT INFORMATION (PLEASE PRINT CLEARLY)

DATE:_____

Legal Name:_____ ☐ M ☐ F Date of Birth:_____Age:____
Preferred Name:_____ Pronouns: ☐He/Him ☐She/Her ☐Other:_____
Address:_____ City:_____State:____Zip:_____
Preferred Phone No.:_____☐Home ☐Cell ☐Work Social Security No.:_____
Secondary Phone No.:_____☐Home ☐Cell ☐Work Occupation:_____
Marital Status: S M D W SEP Spouse Name:_____ Employer:_____
If Under the Age of 18,
Parent(s)/Guardian(s) Name:_____Address:_____
Student Status (circle): Full / PT School Name:_____

Is this visit due to an Auto Accident? (Circle) YES / NO
Is this visit due to a Job Related Injury? (Circle) YES / NO
If you answered yes to either of these questions, please speak to a member of the office staff

Name of Primary Care Doctor:_____Phone:_____Date of Last Visit:_____
Emergency Contact Person:_____Phone:_____Relationship:_____
Pharmacy (Name and location):_____

How did you hear about our practice? ☐ Referral ☐ Internet ☐ Phone directory ☐ Other:_____

PLACE INSURANCE INFORMATION BELOW AND GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST

Primary Insurance:_____
Name of Insured:_____
Date of Birth:_____
Member ID No.:_____
Claims Address:_____
_____

Secondary Insurance:_____
Name of Insured:_____
Date of Birth:_____
Member ID No.:_____
Claims Address:_____
_____

I have provided all the information above and hereby state that it is true and correct to the best of my knowledge.

_____ _____
Patient or Parent/Guardian Signature **Date**

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read and understood the Notice.
Podiatry Services of Ithaca, P.C. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office of Podiatry Services of Ithaca, P.C. and request a revised copy be sent by mail.

_____ _____

Patient Name (please print) **Date**

_____ _____

Parent or Authorized Representative (if applicable) **Signature**

RELEASE OF INFORMATION

☐ YES ☐ NO I authorize Dr. Villagonzalo to discuss and release my medical condition to my primary physician and other physicians as he deems necessary to provide the best possible care.

PLEASE RELEASE MY PODIATRY RECORDS TO:

_____
_____
_____

☐ YES ☐ NO The information authorized for release may include information considered to be communicable or venereal disease, including but not limited to Hepatitis, Syphilis, Gonorrhea, HIV, and AIDS.

I hereby authorize Podiatry Services of Ithaca, P.C. and its representatives to leave the following information on my answering machine. (Please check or initial all that apply. **If all are acceptable, just check or initial #1 below**)

1._____**2 through 6 is OK**
2._____Time, date, doctor's name, and reason for appointments and/or scheduled hospital procedures
3._____Statements indicating that laboratory or hospital tests are normal.
4._____Requests to call your physician regarding results of tests.
5._____Confirmation of a prescription that has been phoned to a pharmacy for you.
6._____Any billing or insurance issues which may arise.

I have read, understood, and/or filled out all of the above information. By affixation of my signature below, I hereby **agree** to all of the above.

_____ _____

Signature **Date**

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MEDICAL INFORMATION

☐ **RIGHT FOOT** ☐ **LEFT FOOT**

PLEASE DESCRIBE YOUR FOOT PROBLEM:_____

_____

HOW LONG HAS IT BEEN BOTHERING YOU? ☐ Days ☐ Weeks ☐ Months ☐ Years
Any past problems with your feet or ankles? ☐ Yes ☐ No If YES, please explain:_____

_____

Employment Conditions: ☐ Sits at Job ☐Stands at Job ☐ Stands/Walks at Job ☐ Retired
Shoe Size:_____ Weight:_____ Height:_____

PAST AND PRESENT MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY TO YOU)

☐ DIABETES (Insulin or Non-Insulin)	☐ Osteo (Aging) Arthritis	☐ High Blood Pressure	☐ HIV/AIDS
☐ Stomach Problems (Ulcers, Colitis)	☐ Rheumatoid Arthritis	☐ Low Blood Pressure	☐ Gout
☐ Childhood Diseases	☐ Kidney Disease	☐ Asthma/Emphysema	☐ Heart Condition
☐ Rheumatic Fever	☐ Cancer	☐ Hepatitis	☐ Liver Diseases
☐ Epilepsy or Seizure	☐ Tuberculosis	☐ Blood Disorders	☐ Stroke
☐ On Coumadin/Blood Thinners	☐ Mitral Valve Prolapse	☐ Fibromyalgia	☐ Lyme Disease
☐ Slow Wound Healing	☐ Heart Murmur	☐ Circulation Problems	☐ Back Pain
☐ Numbness of Feet	☐ Ankle/Feet Swelling	☐ Frequent Infections	☐ Bleeding Problems

OTHERS:_____
Do you smoke? ☐Yes ☐No If Yes, # packs/day:____ Previously smoked? ☐Yes ☐No If Yes, # packs/day___
Do you drink alcohol? ☐Yes ☐No If Yes: ☐1-2 drinks/week ☐1-2 drinks/day ☐more than 2 drinks/day
Have you had surgery? ☐Yes ☐No What type and year? _____

_____

DO YOU HAVE TO BE PRE-MEDICATED WITH ANTIBIOTICS BEFORE HAVING DENTAL WORK DONE? YES / NO

ALLERGIES (PLEASE CHECK ALL THOSE THAT APPLY)

☐ No Known Allergies	☐ Penicillin	☐ Cortisone	☐ Aspirin	☐ Dental Anesthesia
☐ Latex	☐ Bandaids	☐ Tape	☐ Iodine (Seafood)	

☐ Other Allergies, please list:_____

PLEASE LIST ALL MEDICATIONS THAT YOU ARE TAKING INCLUDING OTCs, AND WHAT THEY ARE USED FOR:

_____

_____

_____

Patient Signature **Parent/Guardian Signature** **Date**

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PAYMENT AUTHORIZATION/ INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Podiatry Services of Ithaca, P.C. and/or its staff to disclose my individually identifiable health information to Centers for Medicare and Medicaid Services and/or private insurance carrier(s) for insurance claim purposes.

Podiatry Services of Ithaca, P.C. will use and disclose my health information in order to obtain payment to the doctor for services rendered and allow insurance companies to process the claims. I request that payment of authorized Medicare, Medicaid, and/or private insurance company benefits be made on my behalf directly to Podiatry Services of Ithaca, P.C. for any service furnished to me.

I understand that this authorization is voluntary and that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that Podiatry Services of Ithaca, P.C. will file the claims to my insurance as a courtesy. It is my responsibility to find out what podiatry and medical services are covered under my insurance plan, including my out of pocket cost. **Any charges not covered by my insurance including but not limited to deductibles, co-insurance, co-payments, convenience items, non-covered services, etc. will be my financial responsibility** and payment will be made to Podiatry Services of Ithaca, P.C. at the time service is provided. Furthermore, I will be responsible for payment of services if incorrect insurance information is given at the time of service.
I understand that I will be charged **$75.00 for No Call, No Show and Less than 24 hour notice cancellations.**

If the Guarantor makes no payment, Podiatry Services of Ithaca, P.C. reserves the right to charge reasonable collection and/or attorney fees necessary to collect any debt.

_____ _____

Patient Name (please print) **Date**

_____

Parent or Authorized Representative (if applicable)

_____

Signature