Patient Name: _____ Date of Birth: _____ Date: _____

Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Height: _____ Weight: _____ Shoe Size: _____

Employer: _____ SS#: (LAST 4) _____

Person responsible for bills: _____ Referred to our office by: _____

Patient Physician: _____ last visit with Physician: _____

What is your foot problem? _____ When did this start? _____

Have you had foot treatments before? _____ By Whom? _____

Pain Scale: 0---1---2---3---4---5---6---7---8---9---10 Pharmacy Name: _____

	YES	NO		YES	NO		YES	NO		YES	NO
Diabetes			Cancer			Heart Murmur			Migraines		
Dementia			Kidney Disease			Hepatitis			Emphysema		
High Blood P			Thyroid			HIV			Depression		
Heart Disease			Liver Disease			UTI			Anxiety		
Blood Clots			Blood Disorder			Ulcers			Mental Illness		
Asthma			Anemia			Gout			Pneumonia		
Stroke			Colitis			Eczema			Tuberculosis		

PLEASE CIRCLE ALL THAT APPLY

*SMOKE YES / NO * ALCOHOL SOCIALLY OR DAILY *DRUG USE YES / NO

Allergies:	Yes	No
Penicillin		
Aspirin		
Codeine		
Local Anesthetics		
Sulfa Drugs		
Erythromycin		
Latex		
Contrast Dye		
Surgical Tape		
Other Allergies?		
Please List:		

LIST MEDICATIONS: _____

_____

_____

_____

_____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____

PHONE: _____

DR. BERNARD COPPOLELLI, DPM
134 SANDY BOTTOM RD
COVENTRY, RI 02816
Phone: 401-828-1811

This is a receipt of notice that we are in compliance with HIPAA regulations regarding privacy practices and that we have the HIPAA regulations on file if you would like a copy or would like to review these HIPAA regulations.

I_____. Have been notified that a copy of HIPAA regulations would be given to me for review if I wish to review these regulations and understand they are in force under HIPAA guidelines.

_____ _____

Signature: Date: