PODIATRY CENTER OF EASTERN CT, LLC
DONNA M. BOCCELLI, D.P.M.
Diplomate, The American Board of Foot and Ankle Surgery

Last Name____ First Name______________________________________ MI____
Address____ City__________________________________ State___ Zip_____
Home Phone____________________________ Cell Phone___________________________ Work Phone___________________________
Date of Birth_____/_____/_____ Age_____ Sex____ Marital Status___________ Shoe Size_____ Height______ Weight______
Occupation____________________________ Employer_______________________________________ SSN______________________
Pharmacy/Address____ Primary Care Physician___________________________________
Referred By ____
Reason for Visit (Right/Left)____Length of Symptoms________________

Please check if any of these apply to you:

___ Anemia
___ Arthritis
___ Asthma
___ Cancer
___ Circulatory Disease
___ COPD
___ Dementia
___ Diabetes (Type I or II)
___ Gout
___ Heart Disease
___ Heart Surgery
___ High Blood Pressure
___ High Cholesterol
___ Kidney Disease
___ Neurological Disorder
___ Neuropathy
___ Parkinson's Disease
___ Rheumatoid Disorder
___ Stomach Ulcers/GERD
___ Thyroid Disorder
___ Other: ____
___ NONE

MEDICATIONS:

____
____
____
____

ALLERGIES:

____
____

Do You Smoke? Yes ___ No ___ # of packs/day_____
Are You a Previous Smoker? Yes ___ No ___
Do You Drink Alcohol? Yes ___ No ___
Do You Have Any Artificial Joints? Yes ___ No ___ If Yes, Location/Year of Surgery____

Emergency Contact/Phone____ Relationship___________________

____(Initial) I request that payment of the authorized benefits be paid to either me, or Podiatry Center of Eastern CT, LLC on my behalf, for any services rendered to me by the doctor. I authorize any holder of medical information about me to release to my insurance company and its agents, or any supplier of medical benefits, any information needed to determine those benefits, or the benefits payable to related services.

____(Initial) I hereby give permission to have my feet examined and treated. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I agree to pay all expenses including reasonable attorney's fees, expenses, and court costs incurred in the collection of any sums due and owing for medical services provided. I will notify you of any change in my health status, or in any of the above information, which is true to the best of my knowledge.

____(Initial) I have been offered a copy of the Summary of Notice of Privacy Practices which Podiatry Center of Eastern CT, LLC follows as mandated by HIPAA (Health Insurance and Portability and Accountability Act).

____(Initial) Cancellation Policy: We ask you to contact us to cancel/reschedule your appointment at least 24 hours in advance in order to accommodate patients who are waiting for an appointment. If you do not, we may assess a $50 no-show service charge to your account.

Patient (or Representative) Signature____ Date________________________