# North Providence Foot & Ankle

Angelo J. Bigelli, D.P.M.
Aaron B. Milam, D.P.M.

* FELLOW AMERICAN COLLEGE OF FOOT SURGEONS
* DIPLOMATE AMERICAN BOARD OF PODIATRIC SURGERY

464 Smithfield Road
North Providence, RI 02904
Tel: (401) 353-6050
Fax: (401) 353-1694

Thank you for choosing

North Providence Foot & Ankle

Enclosed is a new patient information sheet for you to fill out. Please remember to bring in your insurance card at the time of visit.

Thank you,

The Office Of:
Dr. Angelo Bigelli D.P.M.
Dr. Aaron Milam D.P.M.

North Providence Foot and Ankle Associates
Dr. Angelo J. Bigelli, Dr. Aaron B. Milam
Board Certified in Foot and Ankle Surgery
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North Providence, RI 02904
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PATIENT CONFIDENTIAL INFORMATION FORM

## PERSONAL INFORMATION

Name Dr. Mr. Mrs. Ms. (circle) | Age | Date of Birth | Sex M F

First _____ Last _____ MI _____

How do you wished to be addressed? _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Pager # _____

Occupation _____ Employer Name _____

Work Address _____ Work Tel: _____ Ext. _____

Marital Status: S M W D (Please circle)

If applicable, name of spouse/life partner/significant other _____

Emergency Contact Person _____ Relationship: _____

Address: _____

_____ Tel: _____

Who referred you to this office? _____

Primary Physician: _____ Tel: _____

Primary Physician Address: _____ City: _____ State: _____

Pharmacy _____ Tel: _____

## INSURANCE INFORMATION:

1st Insurance: _____ Policy #: _____ Subscriber: _____

2nd Insurance _____ Policy #: _____ Subscriber _____

Worker's Compensation: Yes ☐ No ☐ Contact Person at: _____

Liability Case (auto accident, personal injury) Insurance Carrier: _____

## HISTORY

What concern about your foot or ankle brought you to the office: _____

_____

Have you been to another foot specialist for this complaint or other? Yes ☐ No ☐

Please explain: _____

_____

Family history of foot/ankle problems: Yes ☐ No ☐

Explain: _____

_____

Your shoe size: _____ Participate in sports/exercise? Explain: _____

How much do you stand/walk at work each day? _____ Hours/day

Do you currently smoke?
Yes☐ No ☐ If yes, for how many years? _____ How many packs per day? _____
Did you smoke in the past? How many packs per day? _____
Yes☐ No ☐ For How Many Years: _____ When did you quit? _____
Do you drink alcoholic beverages? Yes ☐ No ☐
Approximately how many drinks per day? _____ Per week? _____
Have you ever abused any illegal drugs? Yes ☐ No ☐ If yes, specify? _____
Caffeine Use? Yes ☐ No ☐ How much coffee per day? _____

## FAMILY HISTORY

Please list any medical problems in the following family members; e.g., gout, heart, blood pressure, diabetes, amputations:

Mother _____
Father _____
Brothers _____
Sisters _____
Children _____

## MEDICAL HISTORY

Diabetes? Type I (insulin dependent) or Type II (diet or oral medication)
Yes ☐ No ☐ (Please circle)
How long have you been diabetic? _____ Years. Any diabetic eye, kidney, circulation or nerve problems? Please specify: _____

Circle all that apply:

| | | |
|---|---|---|
| Angina/Heart pain | Ulcers | Anxiety |
| Heart attack | Liver disease | Depression |
| Heart failure | Kidney disorder | Mental illness |
| Irregular heart block | Prostate disorder | Blood clot/phlebitis |
| High blood pressure | Anemia | Migraine/headaches |
| High Cholesterol | Cancer | Epilepsy/seizure disorder |
| Asthma | Stroke | Dementia/Alzheimer's |
| Emphysema | Thyroid condition | Cataracts |
| Pneumonia | Arthritis | Glaucoma |
| Eczema/Psoriasis | Colitis/bowel problems | Fractures |

Other _____
_____

Height: _____ Weight: _____

Please list all medications you take and the doses. Include prescription and non-prescription drugs:

| Medication | Dose | Times/Day | Medication | Dose | Times/Day |
|---|---|---|---|---|---|
| | | | | | |
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| | | | | | |

Do you use?

| | | | | |
|---|---|---|---|---|
| Wheelchair | Yes ☐ | No ☐ | | |
| Cane or walker | Yes ☐ | No ☐ | | |
| Hearing aid | Yes ☐ | No ☐ | Left ☐ | Right ☐ |
| Oxygen therapy | Yes ☐ | No ☐ | | |
| Sleep Apnea Device | Yes ☐ | No ☐ | | |
| Any other medical devices? | Yes ☐ | No ☐ | | |

Please list the major illnesses you have had:

Please list any surgeries you have had in the past and the year they were done:

| Surgery | Year |
|---|---|
| | |
| | |
| | |

Please list any allergies or reactions you may have to medications, foods, latex, rubber gloves, IVP and CAT scan dye. Describe the reaction.

I understand that I am responsible for all non covered services and co pays that my insurance company does not cover.

_____ Date: _____

Patient signature (or parent, if minor)

PLEASE CIRCLE ALL THAT APPLY

GENERAL: Fever, Chills, Nausea, Vomiting, Weakness, Tiredness

HEART: Chest Pain, Shortness of Breath, Leg Swelling

LUNGS: Cough, Wheezing, Congestion

G.I.: Indigestion, Stomach bleeding, Heartburn

URINARY: Excessive Urination, Painful urination, Blood in urine

NEURO: Numbness, Tingling, Weakness, Tremors, Imbalance

ENDOCRINE: Excessive hunger, Excessive thirst, Sweats, Hot/Cold feeling

MUSCLE: Joint swellings, Muscle soreness, Stiffness, Arthritis

DERM: Psoriasis, Eczema, Rashes, Shingles, Warts

IMMUNE: Anemia, Easy bruising, Bleeding, HIV, Hepatitis

ENT: Hearing lost, Nosebleeds, Eye problems

PSYCH: Anxiety, Depression, Sleeping problems

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## Permission to Discuss Medical Care

**Date:**_____

**Patient Name:**_____

I, _____ will allow the physicians at North Providence Foot & Ankle pc to exam me and to discuss any or all findings and issues with my primary care physician and whomever else I designate below:

_____

_____

**This will remain in force indefinitely unless our office is notified in person or by certified mail.**

**When it is necessary to contact you by telephone, that is to confirm or cancel an appointment, to give you information regarding a booking of a test that our office has made for you on your behalf or test results, may we call the telephone numbers which you have provided and if you are not available, may we:**

____**leave a message on your answering service/machine**

____**leave a message with anyone other than yourself**
**name of person or persons**_____
_____

_____**Anyone who answers**

**Telephone Numbers we may call** _____ **Home**
_____ **Work**
_____ **Cell**

**Signed:**_____**Date:**_____

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# ACKNOWLEGEMENT OF RECEIPT OF HIPPA NOTICE OF PRIVACY PRACTICES ("Acknowledgement")

I acknowledge that I have been provided with an opportunity to review or receive a copy of the HIPPA NOTICE OF PRIVACY PRACTICES of this medical office.

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

OR

_____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient

Check one: Parent____ Guardian _____ Power of Attorney_____ Other_____

**Please note : It is your right to refuse to sign this Acknowledgement**

**Medical Office Use Only**

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

__An emergency prevented us from obtaining acknowledgement
__A communication barrier prevented us from obtaining acknowledgement
__The individual was unwilling to sign
__ Other

Staff Member Signature _____ Date: _____