

CORNERSTONE FOOT CARE

COMPREHENSIVE FOOT & ANKLE CARE

Kimberly Ciccerio, DPM

DATE: ____/____/____

PATIENT NAME:

MI Last First

DATE OF BIRTH: ____/____/____ SSN _____

HOME ADDRESS:

STREET _____

CITY/STATE: _____ ZIP: _____

CELL PHONE #: (____) ____-____ MAY WE LEAVE A MESSAGE/TEXT? YES NO

ALT. PHONE #: (____) ____-____ MAY WE LEAVE A MESSAGE? YES NO

E-MAIL: _____ SEX: M F

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? __YES__NO

IF YES, NAME: _____RELATIONSHIP: _____

PHONE #: (____) ____-____

EMERGENCY CONTACT: _____RELATIONSHIP: _____

PHONE #: (____) ____-____

PRIMARY CARE DOCTOR: _____ PHONE #: (____) ____-____

DATE OF YOUR LAST PRIMARY CARE DOCOTOR VISIT _____

PHARMACY: (Name/Location) _____ PHONE #: (____) ____-____

27900 Euclid Ave., Euclid, OH 44132
O. 216.731.3370 - F. 216.731.3880

13333 Lorain Ave., Cleveland, OH 44111
O. 216.941.3338 - F. 216.941.7505



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PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME OF MEDS	DOSE	REASON?
-		

ALLERGIES: NONE KNOWN YES (IF YES, PLEASE LIST)

MEDICAL PROBLEMS: List all medical conditions below:

CURRENT PROBLEM (CHIEF COMPLAINT)

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY?

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

DATE _____

SIGN NAME OF PATIENT, PARENT OR GUARDIAN _____

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