LEXINGTON PODIATRY

BRIAN J. ZINSMEISTER, D.P.M.

Medical, Surgical & Sports Podiatry

76 BEDFORD ST. #31 • LEXINGTON, MA 02420

TEL 781-862-3953

IT IS YOUR RESPONSIBILITY TO ENSURE A REFERRAL IS IN PLACE BEFORE YOUR VISIT OR YOU WILL NOT BE SEEN!
(PLEASE PRINT & FILL OUT ALL 3 PAGES AND SIGN PAGE 1 AND 3)

NAME _____ DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ BUSINESS PHONE _____ CELL PHONE _____

DATE OF BIRTH _ _ / _ _ / _ _ _ _ AGE _ _ SEX ❑ M ❑ F MARITAL STATUS S M W D SEP PARTNER

EMAIL _____

LANGUAGE: ❑ ENGLISH ❑ SPANISH ❑ OTHER: _____

ETHNICITY: ❑ CAUCASIAN ❑ BLACK ❑ ASIAN ❑ HISPANIC ❑ OTHER: _____

REFERRED BY _____ PERSONAL PHYSICIAN _____ SOCIAL SECURITY NUMBER _____

PATIENT'S EMPLOYER _____ POSITION _____

BUSINESS ADDRESS _____

SPOUSE'S NAME _____ SPOUSE'S EMPLOYER _____ SPOUSE'S WORK PHONE _____

PERSON RESPONSIBLE FOR BILL OR INSURANCE *(IF OTHER THAN ABOVE)*

NAME _____ RELATIONSHIP _____

ADDRESS (IF OTHER THAN ABOVE) _____ HOME PHONE _____

EMPLOYER _____ DATE OF BIRTH _____

BUSINESS ADDRESS _____ BUSINESS PHONE _____

INSURANCE INFORMATION

INSURANCE NAME _____ INSURED'S SOC SEC # _____ GROUP # _____ POLICY # _____

1 _____

2 _____

NEAREST RELATIVE TO NOTIFY IN AN EMERGENCY *(IF NOT ALREADY LISTED)*

NAME _____ RELATIONSHIP _____

ADDRESS _____ HOME PHONE _____

EMPLOYER _____ POSITION _____ BUSINESS PHONE _____

A NOTE ABOUT INSURANCE: Insurance policies are contracts between you, the subscriber and the company. The doctor can in no way alter the contract nor guarantee your payments by the company. All fees are rendered to the patient. The receptionist will try to advise you and will fill out all necessary forms that the company may provide, other than that the patient is responsible for all fees. The above information is correct to the best of my knowledge and I consent to treatment by Brian J. Zinsmeister, D.P.M.

DATE _____ PATIENT'S SIGNATURE *(Parent if Minor)* _____

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THIS INFORMATION IS IMPORTANT FOR OUR RECORDS AND YOUR HEALTH.

Describe your foot problem:

_____

_____

How long has it been bothering you? ❑ Weeks_____ ❑ Months_____ ❑ Years_____

Any past problems or surgeries of your feet and ankles?

_____

_____

_____

Shoe Size _____ Current Weight _____ Height _____ Blood Pressure _____ / _____

Are you allergic or sensitive to a medicine or material? ❑ Yes ❑ No *(Specify below)*

_____

Are you Diabetic? ❑ Yes ❑ No
If yes, how long have you been diabetic? _____ Do you take insulin? ❑ Yes ❑ No

Have you had any serious illnesses? ❑ Yes ❑ No

_____

What surgeries have you had?

_____

Are you under a physician's care? ❑ Yes ❑ No If yes, for what condition(s)

_____

_____

Family Physician: _____

Date last seen by this doctor: _____

May we contact your physician about your health? ❑ Yes ❑ No Phone #_____

Name of your Pharmacy _____ Location:_____
Phone # _____

What medications and dosage do you take regularly?

_____

_____

_____

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CHECK (✔ or ✘) **any of the following that you have, or have had a problem with:**

❑ Heart	❑ Asthma	❑ Skin	❑ Unexplained weight loss
❑ Circulation	❑ Stomach Ulcers	❑ Gout	❑ Frequent infections
❑ Arthritis	❑ Hormones	❑ Tuberculosis	❑ Healing
❑ Kidneys	❑ Anemia	❑ Rheumatic Fever	❑ Neurological Disorder
❑ Lungs	❑ Bladder	❑ Liver	❑ Intestines
❑ Cancer	❑ High Blood Pressure		

Do you have any artificial joints or implants?

Hip ❑ Yes ❑ No **Knee** ❑ Yes ❑ No **Other(s)** ❑ Yes_____

Family History

Mother: ❑ Living ❑ Deceased Cause of Death _____

Father : ❑ Living ❑ Deceased Cause of Death _____

Brother: ❑ Living ❑ Deceased Cause of Death _____

Sister: ❑ Living ❑ Deceased Cause of Death _____

Is There a Family History of:	Mother	Father	Brother	Sister
❑ Heart Disease	❑	❑	❑	❑
❑ Arthritis	❑	❑	❑	❑
❑ Bleeding Disorder	❑	❑	❑	❑
❑ Neurological Disorder	❑	❑	❑	❑
❑ Stroke	❑	❑	❑	❑
❑ Bunions	❑	❑	❑	❑
❑ Hammertoes	❑	❑	❑	❑
❑ Flatfeet	❑	❑	❑	❑
❑ Circulation problems in legs or feet?	❑	❑	❑	❑

Do you smoke NOW? ❑ Yes ❑ No If yes, number of packs per day _____

Did you previously smoke? ❑ Yes ❑ No If yes, how many packs per day _____
If yes, number of years smoked _____

Do you drink alcohol? ❑ Yes ❑ No
❑ Light Usage, 1-2 per week ❑ Moderate, 1-2 per day ❑ Heavy, more than 2 daily

Employment? ❑ Sit at job ❑ Stand at job ❑ Stand & Walk at job ❑ Retired

The above information is correct to the best of my knowledge.

Signature _____ *Date* _____

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CONSENT

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's "Notice of Privacy Practices" (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Signature:_____ Date:_____
Patient, parent or legal guardian

If signed by patient's representative, state relationship to patient:_____