



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 _____ BUSINESS _____ CELL _____
PHONE _____ PHONE _____ PHONE _____

DATE OF BIRTH __/__/____ AGE __ SEX M F MARITAL S M W
STATUS 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 _____ HOME PHONE _____
(IF OTHER THAN ABOVE) _____ 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 _____
_____ PHONE _____

EMPLOYER _____ POSITION _____ BUSINESS PHONE _____

_____ 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 X) 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
<input type="checkbox"/> Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neurological Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bunions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hammertoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Flatfeet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Circulation problems in legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 _____

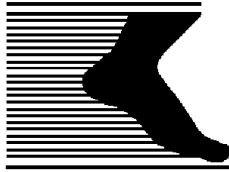
Do you drink alcohol? Yes No
 Light Usage, 1-2 per week Moderate, 1-2 per day Heavy, more than 2 daily

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: _____