*Dr. Mitchell T. Zimmel * 180 White Road * Little Silver, NJ 07739*

(PLEASE PRINT)

Patient's Name First_____Last_____

Home Address_____Town_____State_____Zip_____

Telephone #_____Business#_____

Cell#_____ Email:_____

Date of Birth_____-_____-_____ Sex M___F___ Social Security_____-_____-_____ Marital Status_____

Race _____ Ethnicity _____ Primary Language _____

Employer_____ Occupation_____

Parent's Name (if minor) _____

Family Physician_____ Referred By_____

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Primary Insurance Company_____

Policy#_____ Group#_____

Name of Policy Holder_____ Date of Birth_____-_____-_____ Relationship_____

Secondary Insurance Company_____

Policy#_____ Group#_____

Name of Policy Holder_____ Date of Birth_____-_____-_____ Relationship_____

"I request that payment of authorized Medicare and or private insurance benefits be made on my behalf to Dr. Mitchell T. Zimmel for any services furnished me by Dr. Zimmel or his associates. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I understand there is no guarantee of benefits and that if my insurance company does not pay for services rendered, I will be financially responsible for any balance due. I also understand that if I have no current insurance coverage at time of service that I am financially responsible for all charges incurred. I have read and agree to these terms."

Signature_____ Date_____

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What is your present foot problem? _____
Are you now in good health?..... yes no
Are you now or have you been under a physician's care
During the past two years?..... yes no
Do you have a personal history of diabetes?..... yes no
Have you experienced any effects from Novocain?
Penicillin, or other medication?..... yes no
If so which ones? _____
Have you ever been treated for heart trouble, arthritis?
Asthma, epilepsy, rheumatic fever, kidney or liver ailment?..... yes no
Have you had any serious illness or operations?..... yes no
If yes, what one(s)? _____
Are you presently taking medications or drugs?..... yes no
If yes, give names_____

MEDICARE PATIENTS:

I have not been seen by another podiatrist for routine foot care within the past 60 days. I understand that if I have, Medicare will not pay for routine foot care today and I will be financially responsible for these services.

Signature_____ Date_____