



PATIENT'S NAME: _____
FIRST NAME ----INITIAL -----LAST NAME

Date of Birth: _____ Age: _____ What Name Do You Like To Be Called: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ Home Telephone: _____

Work Telephone: _____ Cell Phone: _____

Social Security #: _____ Sex: M F Weight: _____ Height: _____' _____"

EMERGENCY CONTACT: _____ Relationship: _____

Contact's Home Telephone: _____ (and/or) Work Telephone: _____

PATIENT'S EMPLOYER: _____ Position: _____

Employer's Phone: _____

Employer Address: _____

PRIMARY CARE PHYSICIAN: _____

Primary Physician Address: _____ Telephone _____

PRIMARY HEALTH INSURANCE CO.: _____

Primary Policy No. _____

Name of Subscriber: _____ Subscriber's Date of Birth: _____

Do You Have Other Health Insurance Coverage? Yes No Secondary Policy No. _____

Secondary Health Insurance Company: _____

REFERRED BY: _____

REASON FOR VISIT: _____

Is this a result of **Work Injury**? Yes No or is it a result of an **Auto Accident** Yes No

WORKERS COMP OR AUTO ACCIDENT CARRIER: _____

Claim Number: _____ Date of Accident: _____

Name of Adjuster: _____ Telephone: _____

PATIENT CONSENT FOR EXTENDED AUTHORIZATION AND TREATMENT

- 1) For any insurance plan that requires authorization from a primary care physician (e.g. HMO, PPO, etc.) it is your responsibility (as patient or guardian) to be sure that this office receives all necessary referrals or authorizations PRIOR to treatment. Professional services are rendered and billed directly to your insurance carrier; however you, the patient/guardian, are directly responsible for services rendered by the doctor. A health insurance policy is a contract between you (the patient or subscriber) and your insurance carrier. If for any reason the insurance carrier denies charges, payment for any services rendered will become the responsibility of the patient/guardian.
- 2) I hereby authorize Kenneth M. Leavitt, DPM to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to Kenneth M. Leavitt DPM, all payments for medical services rendered to myself or my dependents. I am aware that it is my obligation to know my insurance company's policies and that I am responsible for payment if I have not fulfilled their requirements. I hereby request and voluntarily consent to such office care, including routine diagnostic procedures and medical treatment as may be deemed necessary by Kenneth M. Leavitt, DPM and his designees.
- 3) I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

x _____
Signature (Parent, if patient is a minor)

Date



PATIENT'S NAME: _____
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Have you ever been diagnosed and/or treated for any of the following conditions? Yes No

CARDIOVASCULAR

- High Blood Pressure
- Chest Pain
- Palpitations/Arrhythmia
- Heart Attack
- Congestive Heart Failure
- Stroke / TIA
- Other: _____

LIVER

- Hepatitis
- Hepatitis B
- Hepatitis C
- Other: _____

MUSCULOSKELETAL

- Fibromyalgia
- Back / Neck Pain
- Osteoporosis
- Other: _____

INFECTIOUS DISEASE

- HIV
- Hepatitis
- Chronic Skin Infections
- Other: _____

LUNG

- Shortness of Breath
- Lung Disease
- Asthma
- Emphysema
- COPD
- Other: _____

KIDNEY

- Kidney Disease
- Kidney Failure
- Recurrent Infections
- Other: _____

NERVOUS SYSTEM

- Seizure Disorder
- Multiple Sclerosis
- Parkinson's Disease
- Other: _____

ENDOCRINE

- Diabetes (insulin dependent)
- Diabetes (non-insulin dependent)
- Thyroid Disease
- Other: _____

GASTROINTESTINAL

- Reflux / Heartburn
- Crohn's Disease
- Ulcerative Colitis
- Irritable Bowel Syndrome
- Bleeding Ulcers
- Other: _____

GENITO-URINARY

- Recurrent Urinary Tract Infections
- Prostate Enlargement
- Prostate Cancer
- Other: _____

HEMATOLOGIC

- Bleeding Disorders
- Clotting Disorder
- History of DVT/Blood Clot
- Other: _____

- Cancer: Type: _____ Treatment: _____
- Do you have medical conditions that are not listed above Yes No
 Please list and explain: _____
- Have you ever had a complication with anesthesia? Yes No If yes, please describe the complication: _____

SURGICAL HISTORY: Please list ALL SURGERIES that you have had below. Provide as much information as possible. If you require additional room, please write them on the back of this sheet.

<u>SURGERY</u>	<u>HOSPITAL/CITY/STATE</u>	<u>YEAR</u>	<u>SURGEON</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____



PATIENT'S NAME: _____
FIRST NAME -----INITIAL -----LAST NAME

ALLERGIES: Do you have any Drug Allergies? ___ Yes ___ No Please list ALL allergies and your reactions

Drug or Food Allergies

What Kind of Reaction?

1. _____
2. _____
3. _____
4. _____

- _____
- _____
- _____
- _____

Are you allergic to adhesive tape? ___yes ___No

Are you allergic to latex? ___Yes ___No

MEDICATIONS: Do you currently take any medications? ___ Yes ___ No Please list ALL current medications

1. _____
2. _____
3. _____
4. _____

5. _____
6. _____
7. _____
8. _____

TOBACCO HISTORY

- I do not use tobacco products
- I smoke ___cigarettes per day.
- I smoke cigars
- I chew tobacco
- I quit smoking in _____(year)

ALCOHOL HISTORY

- I never drink alcohol
- I quit drinking in _____(year).
- I drink most days, _____drink(s) per day
- I infrequently drink alcohol
- I drink ___alcoholic beverages per week
- I have a history of alcohol abuse

X _____
Signature (Parent, if patient is a minor)

Date

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Patient Privacy Act (HIPPA), requires that our office obtains authorization to leave messages at your home with family members or on voice mail, email, etc. **I hereby give my consent for Dr. Kenneth M. Leavitt and staff to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO) as follows:**

1. Dr. Kenneth M. Leavitt and staff's Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Kenneth M. Leavitt and staff reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by writing to Dr. Kenneth M. Leavitt's office at New England Baptist Hospital, 125 Parker Hill Ave. Suite 390, Boston, MA 02120.
2. **PHONE CALLS:** Dr. Kenneth M. Leavitt and staff may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.
3. **MAIL:** Dr. Kenneth M. Leavitt and staff may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements as long as they are marked Personal and Confidential.
4. **E-MAIL:** Dr. Kenneth M. Leavitt and staff may call my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements.
5. I have the right to request that Dr. Kenneth M. Leavitt and staff restrict how they use or disclose my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.
6. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Dr. Kenneth M. Leavitt and staff may decline to provide treatment for me.

I AUTHORIZE

I DO NOT AUTHORIZE

X _____
Signature of Patient or Legal Guardian

Date

Print Patients Name

If applicable Print Name of Legal Guardian