Goldberg Podiatry Center, LLC

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PLEASE PRINT

TODAY'S DATE ____________________ **DIABETIC?** YES_____ NO_____

REFERRAL FROM: WEBSITE/INTERNET **ALLERGIES?** YES_____ NO_____

PROVIDER____________________ HOSP ____________________ PREFERRED LANGUAGE____________________

OTHER PATIENT____________________ OTHER____________________

♂ MALE
♀ FEMALE
( )

LAST NAME **FIRST NAME** **M.I.** **GENDER** **HOME PHONE**

( )

D.O.B **SOCIAL SECURITY #** **CELL PHONE**

ADDRESS **APT#** **CITY** **STATE** **ZIP CODE**

EMERGENCY PHONE (**NOT YOUR HOME #**) CONTACT'S NAME/RELATIONSHIP TO PT **PARENT/GUARDIAN'S FULL NAME**

MARITAL STATUS: SINGLE______ MARRIED______ SEPARATED______ WIDOWED____ DIVORCED______

EMAIL ADDRESS

REQUIRED BY GOVERNMENT:

RACE: AMERICAN INDIAN/ALASKA NATIVE NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ASIAN BLACK OR AFRICAN AMERICAN WHITE

ETHINICITY: NON HISPANIC OR LATINO ______ HISPANIC OR LATINO

PRIMARY CARE PHYSICIAN **PHYSICIAN'S PHONE** **CITY** **LAST VISIT**

PHARMACY NAME & PHONE# CITY PRESCRIPTION PLAN YES NO

EMPLOYMENT INFORMATION

EMPLOYERS' NAME/COMPANY CITY/STATE WORK PHONE NUMBER

PRIMARY INSURANCE INFORMATION

NO INSURANCE. __________

INSURANCE NAME ____________________ ID# ____________________

SUBSCRIBER'S NAME **DATE OF BIRTH** RELATIONSHIP TO THE PATIENT

SECONDARY INSURANCE? ____________________

FOOT PROBLEM BRINGING YOU TO OUR OFFICE ____________________

ON THE SCALE OF 1-10(1=NO PAIN 10=WORST PAIN)

WHAT IS YOUR LEVEL OF PAIN? ________/10 **PLEASE CHECK:** **RIGHT** **LEFT** BOTH

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE PAYMENTS, HOWEVER, THE PATIENT IS RESPOSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE **DR. KARYN GOLDBERG** TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR FOR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. I ACKNOWLEDGE THAT I RECEIVED MY **HIPAA PRIVACY PRACTICES NOTICE**.

PATIENTS WHO HAVE MEDICARE SHOULD BE AWARE THAT CERTAIN SERVICES ARE NOT COVERED BY MEDICARE AND THE PATIENT IS RESPONSIBLE FOR THEIR PAYMENT.**

TODAY'S DATE **PATIENT'S SIGNATURE** --- PARENT'S SIGNATURE (**ALSO PRINT NAME**)

AGE__________ SHOE SIZE __________ PATIENT'S NAME ______________________________

VITAL SIGNS: B.P.______________ PULSE__________ WEIGHT ______________HEIGHT___________

MEDICAL HISTORY AND REVIEW OF SYSTEM:

*** FEMALE ONLY** PREGNANT YES NO
BREAST FEEDING YES NO

CIRCLE MEDICAL CONDITION:

CARDIAC MI CHF HYPERTENSION
ANGINA ARRHYTHMIAS
MURMUR PALPITATION HIGH CHOLESTEROL
INTERMITTENT CLAUDICATION CVA

RESP: ASTHMA COPD SNORING S.O.B
COUGH BRONCHITIS PNEUMONIA
EMPHYSEMA PNEUMONIA SHOT________
FLU SHOT __________

ENDO: DIABETES INSULIN DEP NON INSULIN DATE DX.___________
* **BLOOD SUGAR ______________FASTING: Y___ N___**
* **HBA1C_________** GOUT

OBESITY THYROID OSTEOPOROSIS

BLOOD: ANEMIA LEUKEMIA BLEEDING PROBLEM
AIDS ASA THERAPY

ANTICOAGULANT THERAPY_________________

RENAL: PROSTATE DIALYSIS POLYURIA
HEMATURIA INFECTION

GASTRIC: ULCER REFLUX GASTRITIS HEPATITIS
DIARRHEA CONSTIPATION JAUNDICE

EENT: CATARACT BLURRED VISION
GLAUCOMA SINUSITIS
VERTIGO DYSPHAGIA
FEVER GLASSES CONTACTS

SKIN: TINEA SKIN CANCER
DERMATITIS PSORIASIS
ECZEMA ONYCHOMYCOSIS
ACNE

NEURO: SEIZURE WEAKNESS
PARESTHESIA ANESTHESIA
PARALYSIS PARKINSON'S DISEASE
EPILEPSY DIZZINESS
ALZHEIMER'S

PSYCH: DEPRESSION PSYCH PROBLEMS
ANXIETY

SKELETAL: ARTHRITIS LUPUS
PAIN: BACK NECK KNEE
ANKLE FEET HAND
PAST FRACTURES:

PATIENT'S CANCER HISTORY: YES____NO____

ALLERGIES:
DRUGS:

FOODS:

ENVIRONMENT:

PAST SURGICAL HISTORY

MEDICATIONS:

FAMILY HISTORY:
PARENTS: FATHER: DIABETES, HIGH BLOOD PRESSURE
CANCER

MOTHER DIABETES, HIGH BLOOD PRESSURE

CANCER

SOCIAL HISTORY:

TYPE OF JOB:

SMOKING:

ALCOHOL:

DRUGS:

ACTIVITIES:

LIVES WITH:

ANY CHILDREN?:__________