Goldberg Podiatry Center, LLC

Karyn Goldberg, DPM, FACFAS

Tel. 973-251-2906
Fax 973-369-7035

22 Old Short Hills Road Suite 110
Livingston, NJ 07039

PLEASE PRINT

TODAY'S DATE _____ **DIABETIC?** YES_____NO_____

REFERRAL FROM: WEBSITE/INTERNET **ALLERGIES?** YES_____NO_____
PROVIDER_____HOSP _____ PREFERRED
OTHER PATIENT_____ OTHER_____ LANGUAGE_____

♂ 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**

PATIENT'S EMAIL ADDRESS

MARITAL STATUS: SINGLE_____ MARRIED_____SEPARATED_____
WIDOWED_____ DIVORCED_____

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

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**)

PATIENT'S NAME _____ **AGE_____ SHOE SIZE _____**

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:

If you have **no** medical condition circle: **NONE**

**** ANY RECENT FALLS IN THE PAST 12 MONTHS? YES____ NO____**

CARDIAC: HEART ATTACK PACEMAKER A-FIB
MURMUR PALPITATIONS HYPERTENSION
ANGINA CHF HIGH CHOLESTEROL
INTERMITTENT CLAUDICATION STENT(S)
ARRHYTHMIAS CVA(STROKE)
NONE

RESP: ASTHMA COPD SNORING S.O.B
COUGH BRONCHITIS PNEUMONIA
EMPHYSEMA PNEUMONIA SHOT_____
SLEEP APNEA FLU SHOT _____
NONE

ENDO: DIABETES **INSULIN DEP NON INSULIN**
DATE DX._____ *** HBA1C_____**
*** BLOOD SUGAR _____FASTING: Y___ N___**
GOUT THYROID OSTEOPOROSIS
OBESITY
NONE

BLOOD: ANEMIA LEUKEMIA BLEEDING PROBLEM
AIDS - HIV ASA THERAPY
ANTICOAGULANT THERAPY_____
NONE

RENAL: PROSTATE DIALYSIS POLYURIA
HEMATURIA INFECTION
NONE

GASTRIC: ULCER REFLUX GASTRITIS HEPATITIS
DIARRHEA CONSTIPATION JAUNDICE
NONE

EENT: GLASSES CONTACTS
GLAUCOMA CATARACTS
BLURRED VISION
VERTIGO HEARING AIDS
SINUSITIS DIFFICULTY SWALLOWING
NONE

SKIN: DERMATITIS ACNE
SKIN CANCER TINEA
ECZEMA PSORIASIS
ONYCHOMYCOSIS
NONE

NEURO: SEIZURE EPILEPSY
DIZZINESS PARKINSON'S DISEASE
ALZHEIMER'S WEAKNESS
MIGRANES PARALYSIS
OTHER_____
NONE

PSYCH: DEPRESSION PSYCH PROBLEMS
ANXIETY OTHER_____
NONE

SKELETAL: ARTHRITIS LUPUS
PAIN: BACK NECK KNEE
ANKLE FEET HAND
PAST FRACTURES:
NONE

PATIENT'S CANCER HISTORY: YES____NO____ _____

ALLERGIES:

DRUGS:
FOODS:
ENVIRONMENT:
NONE

PAST SURGICAL HISTORY

MEDICATIONS:

SOCIAL HISTORY:

OCCUPATION:

SMOKING: YES____ NO____ STOPPED _____
HOW MUCH DO YOU SMOKE?_____

ALCOHOL:

DRUGS:

ACTIVITIES:

LIVES WITH:

ANY CHILDREN?:_____

FAMILY HISTORY:

PARENTS: FATHER: DIABETES, HIGH BLOOD PRESSURE
CANCER

MOTHER: DIABETES, HIGH BLOOD PRESSURE
CANCER