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
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

**I am currently a student:
Elementary High School
College Other

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.**

PATIENT'S SIGNATURE PARENT'S SIGNATURE **(ALSO PRINT NAME)** REVISED 2-2020

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

WEIGHT _____**HEIGHT**_____

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

MEDICAL HISTORY AND REVIEW OF SYSTEM:

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 (Hypo or Hyper) OBESITY
OSTEOPOROSIS
NONE

BLOOD: ANEMIA LEUKEMIA BLEEDING PROBLEM
AIDS - HIV
ANTICOAGULANT THERAPY_____
**Aspirin, Clopidogrel, Eliquis, Coumadin, Xarelto, Pradaxa
NONE

RENAL: PROSTATE DIALYSIS POLYURIA HEMATURIA
KIDNEY DISEASE URINARY TRACT INF.
HEPATITIS JAUNDICE
NONE

GASTRIC: ULCER REFLUX GASTRITIS
DIARRHEA CONSTIPATION
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
ALZHEIMER'S PARKINSON'S
MIGRANES WEAKNESS
DIZZINESS PARALYSIS
ADHD ADD AUTSIM
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: YES_____NO_____

HISTORY: _____

ALLERGIES:

DRUGS: _____

FOODS: _____

OTHER: _____

NONE

PAST SURGICAL HISTORY * NONE

_____

_____

_____

MEDICATIONS: *NONE

_____

_____

_____

_____

_____

_____

FAMILY HISTORY:

PARENTS: FATHER: DIABETES, HIGH BLOOD PRESSURE
CANCER HEART DISEASE

MOTHER: DIABETES, HIGH BLOOD PRESSURE
CANCER HEART DISEASE

SOCIAL HISTORY:

OCCUPATION: _____

ACTIVITIES: Running, Walking, Hiking, Swimming, Yoga, Golf
OTHER _____

ALCOHOL: NONE_____SOCIALLY_____

SMOKING: YES___ NO___ STOPPED ___WHEN?_____
HOW MUCH DO YOU SMOKE?_____

DRUGS: _____

LIVES WITH: Alone Spouse Child/Children Roomate Other

ADD'N INFO _____