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

EMPLOYERS' NAME/COMPANY CITY/STATE WORK PHONE NUMBER

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

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. SEE **FINANCIAL POLICY** FOR ADDITIONAL DETAILS.

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)***if applicable

MEDICAL HISTORY AND REVIEW OF SYSTEM

Patient's name _____ **Age**_____**Weight** _____**Height**_____ **Shoe size** _____

CIRCLE MEDICAL CONDITION:

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

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

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

VACCINES **FLU** shot date _____ **PNEUMONIA** shot date_____

COVID -19 Yes No - Pfizer Moderna J&J Dates_____, _____, _____

CARDIAC: HEART ATTACK PACEMAKER A-FIB
MURMUR PALPITATIONS HYPERTENSION
ANGINA CHF HIGH CHOLESTEROL
INTERMITTENT CLAUDICATION STENT(S)
ARRHYTHMIAS CVA(STROKE)
OTHER_____

RESP: ASTHMA BRONCHITIS SNORING COUGH
S.O.B PNEUMONIA EMPHYSEMA
COPD SLEEP APNEA
*COVID 19 -Dx. date_____

ENDO:
DIABETES **INSULIN DEP** **NON INSULIN**
* Dx. date_____ *** HBA1C**_____
BLOOD SUGAR _____**FASTING: Y___ N___**
GOUT THYROID (Hypo or Hyper) OBESITY
OSTEOPOROSIS

BLOOD: ANEMIA LEUKEMIA BLEEDING PROBLEM
AIDS - HIV

ANTICOAGULANT THERAPY_____
**Aspirin, Clopidogrel, Eliquis, Coumadin, Xarelto, Pradaxa

RENAL: PROSTATE DIALYSIS POLYURIA HEMATURIA
KIDNEY DISEASE URINARY TRACT INF.
HEPATITIS JAUNDICE

GASTRIC: ULCER REFLUX GASTRITIS
DIARRHEA CONSTIPATION
OTHER_____

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

EENT: GLASSES CONTACTS
GLAUCOMA CATARACTS
BLURRED VISION
VERTIGO HEARING AIDS
SINUSITIS DIFFICULTY SWALLOWING
OTHER_____

SKIN: DERMATITIS ACNE ECZEMA
SKIN CANCER TINEA
ONYCHOMYCOSIS PSORIASIS
WART(S) OTHER_____

NEURO: SEIZURE EPILEPSY
ALZHEIMER'S PARKINSON'S
MIGRANES WEAKNESS
DIZZINESS PARALYSIS
ADHD ADD AUTISM
OTHER_____

PSYCH: DEPRESSION PSYCH PROBLEMS
ANXIETY OTHER_____

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

PATIENT'S CANCER: YES_____NO_____

HISTORY: _____

ALLERGIES:

DRUGS:_____

FOODS:_____

OTHER: _____

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
Parent(s) Roomate Other

ADD'N INFO _____

Goldberg Podiatry Center, LLC

Financial Policy

1. All co-payments are due at the time of visit. This arrangement is part of your contract with your insurance co. Failure on our part to collect co-payments and deductibles from patients can be considered a violation of the contract you have with your insurance co. Our office accepts cash, checks, credit and debit cards.
2. You are ultimately responsible for payment of charges for services you receive from our office.
3. It is your responsibility to ensure that Dr. K Goldberg is in your insurance network.
4. In accordance with your insurance member handbook, it is your responsibility to provide accurate insurance information and to present your insurance ID card at the time of your visit. If you do not have insurance or do not present a valid insurance card, you will be responsible for payment at the time of service. We will provide you with a copy of our billing form so that you can obtain reimbursement from your insurance company.
5. If your plan requires a referral, it is the patient's responsibility to obtain this prior to being seen by the doctor.
6. Outstanding balances must be paid in full prior to any additional visit unless arrangements have been made before.
7. There is a service fee of $35.00 for each time a check is returned. The bank may return your check up to three times before considering it nonnegotiable. Your insurance company does not cover this fee.
8. A scheduled appointment means that time has been reserved for **you**. Cancellations for appointments must be received at least **6 hours** prior to the scheduled appointment. Cancellations for scheduled surgery must be received at 5 days prior to the scheduled surgery date and time.
9. Patients who fail to keep or don't cancel a scheduled appointment within 24 hours may be charged a **$25.00** No Show Fee. After 3 missed appointments the patient may be discharged from the practice due to excessive missed appointments.
10. Medical record requests must be received in writing at least 72 hours prior to the date needed. Fees for medical records are set in accordance with allowable amounts as defined by the New Jersey Administrative Code. Fees must be received prior to record delivery or pick up.
11. Administrative Services: There is a $25.00 charge for each required administrative service, payable prior to service completion. This administrative service fee covers: form completions for family medical leave and disability, letters for employers, school, and health clubs.
12. In the event your insurance company should happen to send payment to you (the patient), you agree to forward the payment to our office to be applied to your account.
13. SELF-PAY: Payment in full is due at the time of service if you do no have health insurance coverage.

Print patient's name_____

Signature_____**Date**_____