

Goldberg Podiatry Center, LLC
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PLEASE PRINT

TODAY'S DATE _____

DIABETIC? YES _____ NO _____

REFERRAL FROM: WEBSITE/INTERNET _____
PROVIDER _____ HOSP _____
OTHER PATIENT _____ OTHER _____

ALLERGIES? YES _____ NO _____
PREFERRED _____
LANGUAGE _____

LAST NAME _____ FIRST NAME _____ M.I. _____ GENDER MALE FEMALE ()
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 _____

EMAIL ADDRESS _____
WIDOWED _____ DIVORCED _____
RACE: AMERICAN INDIAN/ALASKA NATIVE NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER NON HISPANIC OR LATINO
ASIAN BLACK OR AFRICAN AMERICAN WHITE ETHNICITY: _____ 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

INSURANCE NAME _____ ID# _____ NO INSURANCE. _____

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 RESPONSIBLE 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 PREGNANT YES NO
ONLY BREAST FEEDING YES NO

CIRCLE MEDICAL CONDITION:

CARDIAC HEART ATTACK HYPERTENSION
ANGINA ARRHYTHMIAS PALPITATION
MURMUR STENT(S) PACEMAKER
INTERMITTENT CLAUDICATION CHF
CVA(STROKE)
HIGH CHOLESTEROL

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

RESP: ASTHMA COPD SNORING S.O.B
COUGH BRONCHITIS PNEUMONIA
EMPHYSEMA PNEUMONIA SHOT _____
SLEEP APNEA FLU SHOT _____

SKIN: TINEA
SKIN CANCER DERMATITIS
ECZEMA PSORIASIS
ACNE ONYCHOMYCOSIS

ENDO: DIABETES INSULIN DEP NON INSULIN DATE DX. _____
* BLOOD SUGAR _____ FASTING: Y ___ N ___
* HBA1C _____ GOUT
OBESITY THYROID OSTEOPOROSIS

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

BLOOD: ANEMIA LEUKEMIA BLEEDING PROBLEM
AIDS ASA THERAPY
ANTICOAGULANT THERAPY _____

PSYCH: DEPRESSION PSYCH PROBLEMS
ANXIETY OTHER _____

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

RENAL: PROSTATE DIALYSIS POLYURIA
HEMATURIA INFECTION

PATIENT'S CANCER HISTORY: YES ___ NO ___

GASTRIC: ULCER REFLUX GASTRITIS HEPATITIS
DIARRHEA CONSTIPATION JAUNDICE

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?: _____