Dr. Brian Goldstein

Podiatric Medicine & Surgery of the Foot and Ankle

Patient Information

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____

Social Security #: _____ E-mail: _____

Emergency Contact Name: _____ Number: _____

Gender: Male / Female Marital Status: S M D W Spouse Name: _____

Employer Name: _____ Phone #: _____

Insurance Information

Insurance Company Name: _____ ID #: _____
Subscriber Name: _____ Date of Birth: _____

Secondary Insurance: YES / NO Do you have any Military affiliations: YES/ NO

Employer Name: _____ Phone #: _____

Physician Information:

Family Physician: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

Other Physician: _____ Phone #: _____

Did you sustain an injury at work? YES / NO **Are you injuries accident related? YES/ NO**

HIPPA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and Accountability Act of 1996(HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.

- Obtain payment from designated third-party payers.

Patient's Name: _____ Date of Birth: _____

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Name: _____ **Date:** _____

Allergies:

Drug Yes/No: _____

Food Yes/No: _____

Medications:

Drug	Dose

Previous Surgeries/Serious Injuries:

Surgery/Injury:	Date:

Social History:

Alcohol:	Yes/No
Cigarettes:	Yes/No
Caffeine:	Yes/No
Recreational Drugs:	Yes/No
Special Diet:	Yes/No

Health History:		YOU	FAM	Explain: (Illness/Disease)
Good General health	Yes/No	o	o	
Ear, Nose, Mouth	Yes/No	o	o	
Eyes	Yes/No	o	o	
Gastro/Genitourinary	Yes/No	o	o	
Sleep	Yes/No	o	o	
Cancer	Yes/No	o	o	
Diabetes	Yes/No	o	o	
Kidney Disease	Yes/No	o	o	
Heart Disease	Yes/No	o	o	
Stroke/Mini Stroke	Yes/No	o	o	
Pulmonary	Yes/No	o	o	
Asthma	Yes/No	o	o	
High Blood Pressure	Yes/No	o	o	
High Cholesterol	Yes/No	o	o	
Psychiatric	Yes/No	o	o	
Migraines/headaches	Yes/No	o	o	
Joint problems	Yes/No	o	o	
Muscle problems	Yes/No	o	o	
Skin	Yes/No	o	o	
Back/Neck pain	Yes/No	o	o	
Memory loss/mental confusion	Yes/No	o	o	
Balance Trouble	Yes/No	o	o	
Black outs/loss of conscious	Yes/No	o	o	
Difficulty Speaking	Yes/No	o	o	
Facial Drooping	Yes/No	o	o	
Light-headed or dizziness	Yes/No	o	o	
Neuropathy	Yes/No	o	o	
Numbness or tingling	Yes/No	o	o	
Paralysis	Yes/No	o	o	
Tremors	Yes/No	o	o	
Weakness	Yes/No	o	o	

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NAME:_____ **DATE:**_____

Please Answer all questions to the best of your knowledge:	No Difficulty at all	Slight Difficulty	Moderate difficulty	Extreme Difficulty	Unable to do
Standing	o	o	o	o	o
Walking on even ground	o	o	o	o	o
Walking on even ground, no shoes	o	o	o	o	o
Walking up hills	o	o	o	o	o
Walking down hills	o	o	o	o	o
Going up stairs	o	o	o	o	o
Going down stairs	o	o	o	o	o
Walking on uneven ground	o	o	o	o	o
Stepping up and down curves	o	o	o	o	o
Squatting	o	o	o	o	o
Sleeping	o	o	o	o	o
Coming up to your toes	o	o	o	o	o
Walking initially	o	o	o	o	o
Walking 5 minutes or less	o	o	o	o	o
Walking approximately 10 minutes	o	o	o	o	o
Walking 15 minutes or greater	o	o	o	o	o
Home responsibilities	o	o	o	o	o
Activities of daily life	o	o	o	o	o
Personal care	o	o	o	o	o
Light to moderate work-standing, walking	o	o	o	o	o
Heavy work- pushing, pulling, climbing	o	o	o	o	o
Recreational activities	o	o	o	o	o

Pain:	No Pain	Mild	Moderate/Severe	Unbearable
General level of Pain	o	o	o	o
Pain at rest	o	o	o	o
Pain during your normal activity	o	o	o	o
Pain first thing in the morning	o	o	o	o

Only fill this section if you are a dancer or Sports player:	Not difficult at all	Slightly Difficult	Moderate Difficult	Extreme Difficult	Unable to do
Running, Jumping and landing	o	o	o	o	o
Squatting and stopping quickly	o	o	o	o	o
Cutting, lateral movements	o	o	o	o	o
Low-impact activities	o	o	o	o	o
Ability to perform activities normally	o	o	o	o	o
Participate in sports for desired amount of time	o	o	o	o	o

TOTAL:_____

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I, _____ **authorize Dr. Brian Goldstein and Staff to provide all forms of Podiatry care as would reasonably be expected in an office setting. This includes but is not limited to the bones of the foot and ankle and muscles nerves and skin form the leg to the toes.**

Evaluation services may include but are not limited to: Interview, physical examination, X rays, Muscular-Skeletal Ultrasound, blood tests and evocative testing

Treatment services may include but are not limited to: application of splints, casts and braces, Sharp reduction of nails and skin, wound care, topical and injection application of medication, and health care counseling, physical manipulation and vitamin, and oral administration of vitamin, herbal and prescription medications.

I agree to participate in my care including notifying the office of changes in address, telephone, allergies, medication, and insurance, accidents and hospitalization.

I am aware that no guarantees will be offered or implied as to the outcome of my care.

I am aware that I have the right to ask for explanations of my examination findings and treatment offerings. Questions are encouraged by the office so that I make informed choices about my care and Dr. Goldstein and staff can better deliver my care.

I have read this form and agree to care as provided by Dr. Brian Goldstein and Staff.

Signature: _____ Date: _____

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

As per our billing department we would like to inform you (our patient) that, we do verify all insurance benefits prior to the patients visit. Do keep in mind that this is a courtesy to our patients and all verifying and billing is not a guaranteed of payment for the services provided.

It is important for our patients to understand that you are still financially responsible for the account and any balances not paid by your insurance carrier (s).

I agree to pay any unpaid balances that my insurance carrier (s) does not pay for the services provided to me by Dr. Brian Goldstein.

Signature: _____ Date: _____