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:___________________ **Email:**___________________________________

Emergency Contact Name:_____________________**Number:**_______________________________

Gender: Male/Female Marital Status: S M D W Military Affiliation: Yes /No

Employer Name:_______________________________ **Phone:**____________________

Did you sustain an injury at work? Yes / No Are your injuries accident related? Yes / No

Insurance Information

Insurance Company Name:_______________________________ **ID #:**___________________________

Subscriber Name:_____________________________ **Date of Birth:**______________________________

Physician Information

Family Physician:____________________________**Phone#:**____________________________________

ReferringPhysician:__________________________**Phone#:**____________________________________

Neurologist:_________________________________**Phone#:**____________________________________

Cardiologist:________________________________**Phone#:**____________________________________

Endocrinologist:_____________________________**Phone#:**____________________________________

Pharmacy Name:___________________________ **Phone#:**____________________________________

How Did You Hear About Us? (circle one) Internet/Google Insurance Friend/Family

Doctor (who?)______________________ **Other** ________________________________

Patient's Signature: ______________________________ **Date:** ______________________

Dr. Brian Goldstein
Podiatric Medicine & Surgery of the Foot and Ankle

Name:________________________ **Medical History** Date:_____________________

Allergies: Drug: Yes / No ________________________
Food: Yes / No ________________________

Medication: Drug: Dose:
____
____
____

Previous Surgeries / Serious Injuries: Surgery / Injury: Date:
____
____
____

Social History:

Alcohol:	Yes / No	__________________________________
Cigarettes:	Yes / No	__________________________________
Caffeine:	Yes / No	__________________________________
Recreational Drug:	Yes / No	__________________________________
Special Diet:	Yes / No	__________________________________

Health History

Ear, Nose, Mouth, Eyes	Yes / No	____
Gastro/Genitourinary	Yes / No	____
Sleep	Yes / No	____
Cancer	Yes / No	____
Diabetes	Yes / No	____
Kidney Disease	Yes / No	____
Heart Disease	Yes / No	____
Stroke	Yes / No	____
Pulmonary	Yes / No	____
Asthma	Yes / No	____
High Blood Pressure	Yes / No	____
High Cholesterol	Yes / No	____
Psychiatric	Yes / No	____
Migraines/Headaches	Yes / No	____
Joint problems	Yes / No	____
Muscle Problems	Yes / No	____
Skin Problems	Yes / No	____
Back / Neck Pain	Yes / No	____
Memory Loss	Yes / No	____
Balance Trouble	Yes / No	____
Black out/ Loss of Conscious	Yes / No	____
Weakness	Yes / No	____
Facial Drooping	Yes / No	____
Light Headed / Dizziness	Yes / No	____
Neuropathy	Yes / No	____
Numbness / Tingling	Yes / No	____
Paralysis	Yes / No	____
Tremors	Yes / No	____

Dr. Brian Goldstein
Podiatric Medicine & Surgery of the Foot and Ankle

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.

Signature:____Date:______________

Permission for Release of Patients Private Health Information

Dr. Goldstein is permitted to release my private health information to:

Name:_________________________ Relationship:__________________________________

By means of : Phone______ Email_________ In Person_____________ Fax_____________

I,____________________ authorize Dr.Brian Goldstein and staff to provide all forms of Podiatry care as would be 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 from legs to toes.

Evaluation serves may include but are not limited to: interview, exam, X-ray, Muscular Skeletal Ultrasound, blood test and evocative testing.

Treatment services may include but not limited to: application of splints, cast and braces, Sharpe 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 medication.

I agree to participate in my care including notifying office of changes in address, phone number, allergies, medication, insurance, accidents and hospitalizations.

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 explanation of my exam 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 carte.

Signature: __________________________________Date:___________________________

Dr. Brian Goldstein
Podiatric Medicine & Surgery of the Foot and Ankle

Authorization for Release of Protected Health Information

Patients Name: ___________________ Date of Birth: ______________

I, ________________________ authorize my medical health records be released to Dr. Brian Goldstein, address **308 Levering Mill Rd Bala Cynwyd Pa 19004** or **fax 610-660-5166.**

Dates of information to be disclosed: From _________To_____________
(If left blank send records from past two years)

Your right with respect to authorization:

I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be disclosed by this authorization. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign the authorization in order to receive treatment. I also am aware that I may revoke this authorization by notifying the disclosing medical record department in writing. However, I understand that my revocation will not be effective as to uses and / or disclosures already made in reliance upon this authorization or need for an insurer to contest a claim/policy as authorized by law if signing the authorization was a condition to obtaining insurance coverage.

Signature:________________________________Date:_________________

308 Levering Mill Road
Bala Cynwyd, PA 19004

PHN: (610) 664-9555
FAX: (610) 660-5166

Consent to Obtain Medication History

Our medical practice has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your "medication history." A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer.

An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions.

By signing this consent form you give us permission to collect, and give your pharmacy and your health plan permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your medical record.

The medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to point out to us any errors in your medication history.

I give permission for you to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.

Name:__________________________

Signature:_______________________

Date:___________________________