

Steven S. Goldberg, M.D., P.L.

Board Certified in Orthopedic Surgery & Sports Medicine

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New Patient Registration

Appointment Date: _____	
Patient Name: _____	Date of Birth: _____
Address: _____	
City: _____	State: _____ Zip: _____
Out-of-State Address (if applicable) _____	
City: _____	State: _____ Zip: _____
Home Phone: (_____) _____	Out-of-State Phone: (_____) _____
Cell Phone: (_____) _____	
Email: _____	Social Security # _____ - _____ - _____
Employer: _____	Work Phone: (_____) _____
Emergency Contact: _____	Phone: (_____) _____
Who referred you to Dr. Goldberg? _____	
Who is your Family/Primary Doctor? _____	
Pharmacy Name _____	Phone _____

INSURANCE INFORMATION

Primary Insurance: _____	ID #: _____	Group # _____
Policy Holder: _____	Relationship to Patient: _____	
Policy Holders Date of Birth: _____	Policy Holder Social Security# _____	- _____ - _____
Secondary Insurance: _____	ID #: _____	Group # _____
Is this work related? _____	Date of injury _____	
Is this related to an auto accident? _____	Date of accident _____	

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

The Notice of Privacy Practices for Dr. Goldberg is provided at the front desk. This Notice of Privacy Practices details how your information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction concerning the use of my personal medical information:

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to assignment of benefits apply.

Signed: _____ Date: _____
If minor, responsible parent signature _____

CHIEF COMPLAINT

Age: _____ Handed: Right Left Sex: Male Female

Occupation: _____ Hobbies: _____

What is the reason for the visit today? _____

Where is your problem (Please include Right or Left) _____

When did this problem first occur (or date of injury) _____

How did this problem/injury occur? _____

Have you seen another physician for this problem? _____ If yes, who and when? _____

What type of treatment have you had? _____

What severity level would you use to describe your pain? (On a scale 0= no pain, 10= worst pain ever)

- 1 2 3 4 5 6 7 8 9 10

How would you describe the quality of this problem/injury?

- burning dull tingling sharp throbbing other _____

When does this problem occur (the onset)?

- at night with activity at work at rest no particular pattern other _____

Do any of the following improve the problem?

- heat cold rest exercise medication name: _____

Have you had other symptoms with this problem? _____

ALLERGIES

Are you allergic to any medications? No Yes: Name _____

PAST MEDICAL HISTORY Do you have any of the following medical problems?

I have no known medical problems

- Anxiety Diabetes, Type 2 Osteoporosis
- Arthritis, osteo(degenerative) Emphysema Pulmonary Embolism
- Arthritis, rheumatoid GERD Parkinson's disease
- Asthma Heart attack year _____ Seizure disorder
- Blood clots (DVT) Hepatitis A B C Stroke
- Cancer type _____ High cholesterol Thyroid disease
- COPD High blood pressure Ulcer disease
- Coronary artery disease Kidney disorder type _____ Other
- Depression Neuropathy _____
- Diabetes, Type 1 Osteopenia _____

SURGICAL HISTORY

Have you ever had any operations / major surgery?

Procedure	Date	Procedure	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

