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

SURGICAL HISTORY

Have you ever had any operations / major surgery?

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

MEDICATIONS

Medication Name	Dose	Times per Day

FAMILY HISTORY

Mother: Is your MOTHER **alive**? YES NO Age Deceased _____

Father: Is your FATHER **alive**? YES NO Age Deceased _____

Has your **MOTHER** or **FATHER** ever had any of the following diagnosed?

- ☐ Diabetes _____
- ☐ Heart disease_____
- ☐ Stroke _____
- ☐ Cancer_____

SOCIAL HISTORY

Do you smoke? _____ How often? _____

Do you drink? _____ How often? _____

Marital Status (optional): ☐Single ☐Married ☐Divorced ☐Widow

REVIEW OF SYSTEMS

Do you have any of the following symptoms?

Constitutional
- ☐ Loss of appetite
- ☐ Unexpected weight loss
- ☐ Fever
- ☐ Chills

Eyes
- ☐ Difficulty seeing
- ☐ Recent changes in vision

Ears, Nose, Mouth, Throat
- ☐ Nose bleeds
- ☐ Difficulty swallowing

Cardiovascular
- ☐ Chest Pain
- ☐ Irregular heartbeat
- ☐ Swelling in the legs

Respiratory
- ☐ Difficulty breathing
- ☐ Cough
- ☐ Wheezing

Gastrointestinal
- ☐ Abdominal cramping
- ☐ Heartburn
- ☐ Nausea/Vomiting

Musculoskeletal
- ☐ Joint pain or stiffness
- ☐ Joint swelling
- ☐ Muscle pain

Neurological
- ☐ Dizziness
- ☐ Tremors
- ☐ Poor balance

Psychiatric
- ☐ Anxiety
- ☐ Depression

Hematological
- ☐ Bleeding tendency
- ☐ Bruising tendency

Endocrine
- ☐ Excessive Thirst
- ☐ Heat/Cold Intolerance

Skin
- ☐ Rash
- ☐ Itching
- ☐ Poor healing

Everything I have answered is true and correct to the best of my knowledge.

Patient Signature Date