Welcome to the Office of Dr. Stuart Goldman

GENERAL INFORMATION

Date _____

Patient_____

Address_____

_____ _____ _____

City State Zip

Sex: ☐M ☐F Age _____ Birthdate _____

Shoe size_____ Height _____ Weight _____

☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Patient SS# _____

Occupation _____

Employer/school _____

Spouse's Name _____

Spouse's Employer _____

Your Primary Care Doctor _____

Other Physicians: _____

_____ _____

Who referred you to our office?

Dr. _____ Patient_____

Preferred Pharmacy _____

Address _____

Phone # _____ Fax # _____

Preferred Lab for Blood Work

_____Quest _____ Lab Corp Other _____

Social History

Do you currently **smoke?** No Yes _____

DId you previously smoke? No Yes Details: _____

_____

Alcohol use: _____ Limited, less than 3 drinks a week

_____ Social, up to 10/ week _____ Heavy

Recreational drugs: ___ None ___ Marijuana ___ Cocaine

____ Narcotics Other_____

Activity Level: ___ Inactive ___ Limited (< 30 minutes/day)

___ Moderate (30-60/day) ___ Active (>60 minutes/day)

Active sport? _____

CONTACT INFORMATION:

Home _____ _____

Cell Phone _____ _____

E Mail : _____

Emergency Contact _____

Relationship____ Cell Phone _____

Insurance information

Primary Insurance _____

Secondary Insurance _____

Account guarantor (if not the patient):

_____

_____

CURRENT MEDICATIONS ____NONE

	Medication	Dose	Frequency
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____

ALLERGIES: ____ NONE

_____ Local Anesthetic ____ Penicillin

_____ Sulfa ____ Tape (Adhesive)

_____ Iodine on Skin ____ Aspirin

_____ Other _____

_____

Problems with Medication? _____ NONE

_____ Antibiotics _____

_____

_____ Anti Inflammatory Meds:_____

_____

____ Other_____

_____

PLEASE COMPLETE THE ADDITIONAL PAGES OF THIS INFORMATION SHEET.

Chief complaints or concerns at this time: **Duration of Problem**

1._____ _____

2._____ _____

3._____ _____

4._____ _____

5._____ _____

Have you been treated for these concerns ____No _____Yes Prior Treatment: _____

_____ _____ _____

Please note current or prior significant concerns:

_____ Corns & Calluses _____ Ingrown & Fungus Nails _____ Skin Growths

_____ Bunions _____ Hammertoes _____ Tendon Pain

_____ Foot Cramps in shoes _____ Foot or Leg Pain or Cramps at Night

_____ Diabetic Foot Care _____ Neuropathy _____ Burning Feet

_____ Flat Feet _____ Heel or Arch Pain _____ High Arched Feet

_____ Morton's Neuroma _____ Tarsal Tunnel Syndrome _____ Rheumatoid Arthritis

_____ Foot Ulcer / Infections _____ Leg Ulcer / Infections _____ Blood Clot

_____ Swollen Leg or Legs _____ Frequent headaches _____ Poor Balance

_____ Fibromyalgia _____ Gout _____ Sleep Apnea

Difficulty: _____Standing in place _____ Bending over to pick things up

_____ Sitting for a long time _____ Getting Up from a seated position

_____ Walking Limitations from Foot or Leg Pain _____ Foot/Leg Pain of Unknown Cause

_____ Shortness of Breath with walking _____ Depression

Discomfort or arthritis symptoms of :

_____ Low Back _____ Neck _____ TMJ _____ Shoulder Left Right

Right _____ Hip _____Knee _____Ankle **Left** _____ Hip _____Knee _____Ankle

Other: _____

Have you had treatment for POOR CIRCULATION __ No ____Veins ____ Arteries

Have you had treatment for Spinal Stenosis? ___ No ___ Yes _____

Have you fallen or almost fallen due to balance problems? ___ No ___ Yes

Have you previously had custom Orthotics? No Yes _____

Have you previously had custom Ankle Braces? No Yes _____

Please list Foot surgery or any joint replacements, and complications with surgery: ____NONE

_____ _____

Please list other Major Surgery **_ NONE** _____

_____ _____

PLEASE COMPLETE THE ADDITIONAL PAGES OF THIS IFORMATION SHEET.

Do you have Diabetes? **__No __Yes Diagnosed in what year?** _____

Type 1 Type 2 What was your last HBA1c? _____ When? _____

Which Doctor helps you manage your Diabetes _____

Complications of Diabetes? _____ No _____ Yes Circle: Foot infection Neuropathy

Circulation Problem Kidney Problem Vision Problem Heart Problem Digestion Problem

Have you had heart or vascular problems? ___ No ___ Yes

_____ Heart Attack _____ Heart Surgery _____ Heart Failure

_____ Stroke _____ Phlebitis/Blood Clot _____ Venous Disease

_____ Peripheral Artery Disease _____ Artery or vein surgery

Explain Please _____

_____

Infectious disease? ___NONE Circle **HIV / Aids** **Hepatitis type _____**

Other_____

Have you had any Skin Cancers? ☐No ☐Yes

If so, what kind? _____

Do you have a family history of skin cancer? ☐No ☐Yes

If so, what kind, and who had it? _____

_____

General Stress Level Low Moderate High

Explain concerns _____

Are you now or previously diagnosed with any of the following conditions? ___ NONE

____ Anxiety / Nervous Disorder _____

_____ Anemia _____ Bleeding Disorder _____

_____ Asthma _____ Kidney Failure _____ Kidney problems

_____ GastroEsophogeal Reflux(GERD)_____ Stomach Ulcers _____ Stomach problems

_____High cholesterol _ _____Liver disease _____Emphysema _____COPD

Any other medical information you want to share? _____

_____

_____

Family History (please circle): ___NONE

Family Diabetes Father Mother Sibling Other _____

Family Complications: Amputation _____ Heart Disease _____

Rheumatoid Arthritis _____

Any other information you want to share? _____

_____

YOU MUST SIGN (IN 2 PLACES) THE NEXT (LAST) PAGE OF THIS FORM.

May we contact your home and leave a message on your answering machine or voice mail, or discuss your medical condition with other residents? YES NO

We contact patients electronically to remind of appointments. How would you prefer to be contacted?

E Mail _____

Cell Phone (text) _____

We ask that you confirm the appointment in order to keep the appointment available.

- **I ask that you PLEASE communicate about appointments that need to be changed.**
- **Failure to keep scheduled appointments may be grounds for dismissal from our practice.**
- ******** DR. GOLDMAN CURRENTLY HAS A LIMITED PART TIME PRACTICE AND MAY NOT BE REACHED WHEN NOT IN THE OFFICE. WE DO NOT PROVIDE CARE FOR FRACTURES, MAJOR INFECTIONS, OR ANY EMERGENCY CARE. ********
- If you need access to your notes, they are available through your patient portal.
- **IF EMERGENCY CARE IS NEEDED YOU MUST CONTACT YOUR PRIMARY CARE PHYSICIAN REGARDING DIRECTION OR GO TO AN EMERGENCY ROOM.**

I hereby acknowledge the above information, and the opportunity to review and receive all HIPAA privacy forms as presented by the staff of Dr. Goldman.

********** _____ _____

Patient or representative **Date**

Is this visit in response to a current or pending automobile accident, Legal case, traumatic injury, or workers compensation injury? ___ No ___ YES Name of your attorney: _____

I hereby state that the insurance documents I have provided are accurate and up to date.

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage as presented with documents, and assign directly to Dr. Stuart Goldman all insurance benefits, if any, otherwise payable to me for services rendered.

I **understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.**

*****

_____

Responsible Party Signature

_____ _____

Relationship Date