Steven S. Goldberg, M.D.

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: _____

Driver License #_____ Social Security #_____-_____-_____

Employer: _____ Work Phone: (_____)_____

Emergency Contact: _____ Phone: (_____)_____

Who referred you to Dr. Goldberg? _____

Who is your Family/Primary Doctor? _____

INSURANCE INFORMATION

Primary Insurance:_____ ID #:_____ Group # _____

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

Policy Holder: self other :_____ Relationship to Patient:_____

Policy Holders Date of Birth:_____ Policy Holder Social Security# _____-_____-_____

Secondary Insurance:_____ ID #:_____ Group # _____

Address:_____City:_____State:_____ Zip:_____

Is this work related? _____ Date of work 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) _____

How long have the problem/symptoms been present? _____

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)

0 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?

bruising feeling of giving way locking clicking swelling other _____

Do you use an assistive device to get around? _____ cane walker crutches wheelchair

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, childhood onset
Diabetes, adult onset
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
What medications are you currently taking? Please include both prescription and non-prescription medications.

Medication Name	Dose	Times per Day

ALLERGIES
Are you allergic to any medications? No Yes: Name_____

FAMILY HISTORY
Has anyone in your *immediate family* ever had any of the following? (List the relative)

Diabetes _____ Stroke _____
Heart disease _____ Cancer – type_____
Bleeding disorder _____ Other _____

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? I have none of these 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