Goldberg Podiatry Center, LLC

Karyn Goldberg, DPM, FACFAS

Tel. 973-251-2906
Fax 973-369-7035

22 Old Short Hills Road Suite 214
Livingston, NJ 07039

PLEASE PRINT

TODAY'S DATE _____ **DIABETIC?** YES_____NO_____

REFERRAL FROM: WEBSITE/INTERNET _____ **ALLERGIES?** YES_____NO_____

PROVIDER_____HOSP _____ PREFERRED

OTHER PATIENT_____ OTHER_____ LANGUAGE_____

♂ MALE
♀ FEMALE

LAST NAME **FIRST NAME** **M.I.** **GENDER** **HOME PHONE** ( )

D.O.B **SOCIAL SECURITY #** **CELL PHONE** ( )

ADDRESS APT# **CITY** **STATE** **ZIP CODE**

EMERGENCY PHONE (**NOT YOUR HOME #)** CONTACT'S NAME-**RELATIONSHIP TO PT** *** PARENT/GUARDIAN'S FULL NAME**

PATIENT'S EMAIL ADDRESS

MARITAL STATUS: SINGLE_____ MARRIED_____SEPARATED_____ WIDOWED_____ DIVORCED_____

RACE: AMERICAN INDIAN/ALASKA NATIVE NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER WHITE ASIAN BLACK OR AFRICAN AMERICAN

ETHINICITY: NON HISPANIC OR LATINO HISPANIC OR LATINO

PRIMARY CARE PHYSICIAN **PHYSICIAN'S PHONE** **CITY** **LAST VISIT**

PHARMACY NAME & PHONE# **CITY** PRESCRIPTION PLAN YES NO

EMPLOYMENT INFORMATION

EMPLOYERS' NAME/COMPANY CITY/STATE WORK PHONE NUMBER

**I am currently a student:
Elementary High School
College Other

PRIMARY INSURANCE INFORMATION

NO INSURANCE. _____

INSURANCE NAME _____ ID# _____

SUBSCRIBER'S NAME **DATE OF BIRTH** RELATIONSHIP TO THE PATIENT

SECONDARY INSURANCE? _____

FOOT PROBLEM BRINGING YOU TO OUR OFFICE _____

ON THE SCALE OF 1-10(1=NO PAIN 10=WORST PAIN)

WHAT IS YOUR LEVEL OF PAIN? _____/10 **PLEASE CHECK:** **RIGHT** **LEFT** **BOTH**

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE PAYMENTS, HOWEVER,

THE PATIENT IS RESPOSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. SEE **FINANCIAL POLICY** FOR ADDITIONAL DETAILS.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE **DR. KARYN GOLDBERG** TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND HEREBY

ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR FOR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. I ACKNOWLEDGE THAT I RECEIVED MY **HIPAA PRIVACY PRACTICES NOTICE**.

***PATIENTS WHO HAVE MEDICARE SHOULD BE AWARE THAT CERTAIN SERVICES ARE NOT COVERED BY MEDICARE AND THE PATIENT IS RESPONSIBLE FOR THEIR PAYMENT.**

PATIENT'S SIGNATURE PARENT'S SIGNATURE **(Also print name)***if applicable