

PATIENT INFORMATION

Patient's Name

Today's Date: _____

Name: Last _____ First _____ MI _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home: () _____ Work: () _____

Cell Phone: _____

Sex: M F Marital Status: S M D W

Race: _____ Nationality: _____ (This info may help with diagnosis/treatment.)

Age: _____ Date of Birth: _____ SSN: _____

Employer (If Applicable): _____

Address: _____

Phone: _____

Responsible Party (Complete if different from above or if the insurance is under another person's name):

Name: Last _____ First _____ MI _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home: () _____ Work: () _____

Date of Birth: _____ SSN: _____ Relationship to Pt: _____

HOW DID YOU HEAR ABOUT DR. GOLDIN?

Circle your response(s):

Patient Physician Yellow Pages Insurance Hospital Return Patient
Referral Name: _____ Relationship: _____

MEDICAL INFORMATION

PHYSICIANS:

PRIMARY: _____ Address: _____

OTHER: _____ Address: _____

PHARMACY: Name: _____ Location: _____

MEDICAL CONDITIONS: *Circle conditions below that apply to you.*

High Blood Pressure; Strokes/TIA; Diabetes; Congestive Heart Failure; Arthritis; Peptic
Ulcers; Angina/Heart Attacks; Hayfever; Asthma/Hives; Eczema; Psoriasis; Thyroid;
Seizures; AIDS/HIV; Hepatitis; High Cholesterol/Triglyceride; Blood Clots;

Spinal Stenosis , Bleeding disorders

Hysterectomy _____ date Tubal ligation _____ date

Skin Cancer: Basal Cell Carcinoma Squamous Cell Carcinoma Melanoma

Other Cancers: _____

Other Illnesses: _____

OPERATIONS: *Circle conditions below that apply to you.*

Coronary Artery Bypass Pacemaker Defibrillator
Valve Replacement Joint Replacements Stents

Plastic Surgery: What procedures? _____

Other Surgeries: _____

CURRENT MEDICATIONS: *Circle medications below that apply to you.*

Have you taken Accutane in past? When? _____ How long? _____

Birth Control Pills/Hormone Replacement: Name: _____ Date began: _____

Aspirin Coumadin Insulin Preop Antibiotics Allergy Shots Depo Provera Shots

Vitamins/Supplements/Herbs: _____

Other Medications: How long? _____ Other Medications: How long? _____

() I do not take any medications.

FEMALE PATIENTS: Periods are regular/irregular; Normal cycle is _____ days

Postmenopausal Attempting pregnancy (or having unprotected sex)

Nursing Pregnant: Weeks: _____ Pregnancies: _____ Births: _____

My last child was born _____ months/yrs ago (if within the last 3 years)

FAMILY HISTORY: *Circle conditions below which apply to your family.*

Acne Psoriasis Hives Eczema Hayfever Asthma

Skin Cancer Other: _____

ALLERGIES TO MEDICATIONS: _____

() I have no known allergies to medications

SOCIAL HISTORY:

Occupation: _____ School: _____

Who lives with you at home? _____

Do you go to tanning salons? Yes No (If yes, I recommend that you stop.)

IN CASE OF EMERGENCY NOTIFY:

Name: _____

Address: _____

Relationship: _____ Phone: _____

CURRENT PROBLEMS (ROS):

Circle conditions that apply to you:

Constitutional: Fever Weight Loss Night Sweats Fatigue

Skin: Rashes Itching Hair Change Nail Change

Eyes: Loss of Vision Distorted Vision Eye Pain

ENT: Loss of Hearing Ringing Dizziness Sinus Congestion Runny Nose
Nosebleeds Hoarseness Dryness

Cardiovascular: Chest Pain Palpitations Swelling of Legs

Pulmonary: Cough Shortness of Breath Wheezing

Endocrine: Heat or Cold Intolerance Excessive Thirst or Hunger

Gastrointestinal: Swallowing Difficulty Heartburn Diarrhea Constipation
Vomiting Incontinence

Genitourinary: Urinary Frequency Urinary Pain Blood in Urine Incontinence

Males: Penile Discharge Lumps on Testicles

Females: Breast Lumps/Discharge Vaginal Bleeding/Discharge

Musculoskeletal: Joint Pain Muscle Pain/Cramps

Neurological: Headaches Numbness/Tingling Weakness Blackouts Slurred Speech

Psychiatric: Anxiety Depression Mania

Hematological: Easy Bruising/Bleeding Anemia

Immunological: Frequent Infections Swollen Lymph Glands

Other Problems:

() I have none of these problems listed above.

WHAT IS THE MAIN REASON YOU CAME TODAY?

OFFICE POLICY, RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS

I certify that the above information is complete and accurate.

I authorize Harry M. Goldin, M.D. to release any information required to process insurance claims. I authorize payment directly to Harry M. Goldin, M.D. for all the surgical, medical and/or laboratory benefits. I authorize automatic cross-over from Medicare to my secondary insurance.

I understand that:

- I am financially responsible for any uncovered services, which includes reasonable costs and fees of any collection activities for unpaid amounts.
- **24 hour notice** is required if I am unable to keep my scheduled appointment. I will be billed **\$25.00 for every 15 minutes** scheduled that is missed or not cancelled before 24 hours. This includes appointments not kept due to not having a valid HMO referral.
- All **surgical appointments** require **72 hours notice** of cancellation to avoid being charged at the rate of **\$200.00 per hour**.
- I will be billed an **additional \$10/month** if I do not pay my **copay** on the date I am seen.
- A fee determined by state law will be charged if I request a copy of my medical records.

This office cannot schedule **HMO appointments** without a valid referral from the primary care physician and/or the HMO. I agree to be financially responsible for charges incurred if I come without a valid HMO referral. It is my (the patient's) responsibility to obtain the HMO referral

Signature of Insured or Authorized Person (You must be over 18 years old to sign)

Relationship to Patient

BE SURE TO ASK ABOUT:

- **RESTYLANE/PERLANE** for filling in facial wrinkles and creating fuller lips.
- **BOTOX INJECTIONS** for frown lines and crows feet.
- **SCLEROTHERAPY** for unsightly leg veins.

We are accepting new patients and appreciate the confidence you show in us when you refer your family and friends. We see patients of all ages, from infancy to senior citizens.