# Goldin Premier Medicine

Ronald Goldin, M.D., P.A.

## Patient Registration Form

Name:_____ Date of Birth:_____ Age:_____

Address: _____ City:_____ State:_____ ZIP: _____

Home Phone: _____ Cell: _____ Race/Ethnicity: _____

Marital Status:_____ Employer:_____ Work#:_____

Spouse Name: _____ Employer: _____ Phone: _____

Emergency Contact:_____ Phone:_____ Relationship:_____

Primary Insurance Company:_____

Subscriber's Name & Date of Birth:_____

Referred by:_____

Pharmacy Name:_____Pharmacy Phone:_____

Pharmacy Location:_____

Email Address:_____

**Guarantee of Payment:**

I fully understand that I am directly responsible for payment to the Physicians in this office for all medical services rendered to me. I also understand that all bills are payable and become due at the time services are rendered, unless other arrangements have been made. I agree to pay all collection costs including reasonable attorney's fees and costs in the event it becomes necessary to file suit to effect payment. I authorize payments to be made directly to my doctor.

### Authorization to Release Information:

I hereby authorize the physicians in this office to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing any insurance claim.

### Assignment of Insurance Benefits:

If insurance claims are filed by this office on my behalf, I hereby authorize direct payment of any benefits to the physicians in this office for medical or surgical treatment received by me. In this circumstance, I understand that I am financially responsible for any charges not covered by the insurance. I permit a copy of the authorization to be used in place of the original.

**Print Name:_____ Signature:_____Date_____**

**Medication AND Supplements AND Over the Counter Drugs**

| Medication | Dosage and Frequency |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**Past Medical History:** Are you now or have you ever been treated for any of the following?

**Please add any not specifically noted.**

- ❑ Coronary Artery Disease
- ❑ Mitral Valve Disease
- ❑ Elevated Cholesterol/Triglycerides
- ❑ Type II Diabetes
- ❑ Shortness of Breath
- ❑ Emphysema/COPD
- ❑ Heartburn/GERD
- ❑ Hiatal Hernia
- ❑ Arthritic or Degenerative Joints
- ❑ Low Thyroid Function
- ❑ Fibromyalgia
- ❑ Depression
- ❑ Bipolar Disorder
- ❑ Personal History of Colon Cancer
- ❑ Irritable Bowel Disease
- ❑ Obesity

__ Aortic Valve Disease
__ High Blood Pressure
__ Asthma
__ Sleep Apnea Syndrome
__ Gout
__ Hemorrhoids
__ Gallstones
__ Low Back Pain
__ Varicose Veins
__ Anxiety Disorder
__ Personal History Breast Cancer
__ Hepatitis
__ Kidney Stones
__ Other_____
_____
_____

**Allergies:** ___ I have no known drug allergies **OR** ___ I am allergic to the following DRUGS:

| | | |
|---|---|---|
| | | |
| | | |
| Food Allergies? __Yes __No | | Latex Allergy? __Yes __No |

**Print Name: _____ Date: _____**

**Vaccinations:**

Have you received the following vaccinations? Please include the year if known:

Tetanus, Diphtheria & Pertussis (Tdap) ____Yes ____No Year_____

Pneumonia (Prevnar 13) ____Yes ____No Year_____

Flu ___Yes ___No

Pneumonia (Pneumovax 23) ____Yes ____No Year_____

Hepatitis B ____Yes _____No Year_____

Shingles ____Yes ____No Year_____

Other:_____

**Women:**

Have you ever been pregnant? ___Yes ___No

If so, how many times?_____

Deliveries? _____ Miscarriages? _____ C-Sections? _____

When was your last...? Mammogram _____ PAP/ Gyn Exam _____Bone

Density_____

Colonoscopy _____ Menopausal Age _____

**Men:**

When was your last….? Prostate (rectal) exam_____ Colonoscopy

_____

**Surgical History- <u>Please add any not specifically noted.</u>**

Please list any and all operations you have had in your entire life, including **cosmetic or plastic surgery**

| OPERATION | YEAR(S) | OPERATION | YEAR(S) |
|---|---|---|---|
| Tonsillectomy/ Adenoidectomy | | Appendectomy | |
| Laparoscopic Gallbladder | | Open Incision Gallbladder | |
| Total Abdominal Hysterectomy | | Vaginal Hysterectomy | |
| Coronary Bypass (CABG) | | Carotid Endarterectomy | |
| Colon / Large Intestine Surgery | | Prostate Surgery/ Radiation | |
| Breast Biopsy __R __L __Both | | Mastectomy __R __L __Both | |
| Breast Enlargement/Reduction | | Breast Reduction | |
| Liposuction | | Tummy Tuck | |
| Hernia Repair | | Spleen Removal | |
| Hip Replacement __R __L __Both | | Knee Replacement __R __L __Both | |
| Heart Valve Replacement | | Coronary Artery Stenting | |
| C-Section | | Other: | |

| | | | |
|---|---|---|---|
| Others: | | | |
| | | | |

**Hospitalization**

| Name | Reason | Date |
|---|---|---|
| | | |
| | | |
| | | |

**Print Name: _____ Date: _____**

**Family Medical History:** Which of the following diseases **"run in your family"**. Please add anything not listed.

| Disease | Family Member | Disease | Family Member |
|---|---|---|---|
| Heart Disease | | High Blood Pressure | |
| Prostate Cancer | | Obesity | |
| Diabetes | | Lung Disease | |
| Stroke | | Kidney Disease | |
| Breast Cancer | | Colon Cancer | |
| Osteoporosis | | Other | |

Are your parents living? (L) or deceased? (D) **Father** ___ **Mother** ___

Do you have any siblings? Yes (Y) No (N) _____ If so, how many sisters? _____ brothers? _____

**Social History:**
What is your occupation? _____ retired? _____
Do you have any children? _____ Number of daughters? _____ sons? _____
Who lives at home with you? ___Alone ___Spouse____Family____Domestic partner____Roomate___
Marital Status: ____Married _____Single_____Divorced_____Widow____Domestic Partner ____
Do you have any pets? _____Yes _____No If yes, what type? _____
Do you exercise? _____Yes _____No If so, what type and how often? _____
Are/were you a victim of domestic-sexual abuse? _____Yes _____No If so, how long? _____

Do you use any of the following?

| Substance | Amount | How Often | How Many Years |
|---|---|---|---|
| Alcohol___current(C) ___former(F) | | | |
| Tobacco _____C _____F | | | |
| Recreational Drugs _____C _____F | | | |
| Caffeine _____C _____F | | | |

**Personal Physicians:** If you would like for us to communicate your progress with your other physicians, **please provide their names.**

| Specialty | Physician Name | Phone & Fax Number |
|---|---|---|
| | | |
| | | |
| | | |

**Print Name:** _____ **Date:**_____

## Review Of Systems: Please check all symptoms that you frequently experience.

1. General: ____ Change in appetite _____ Chills _____ Fatigue _____ Fever ____ Weight gain _____ Weight loss

2. Eyes: _____ Diminished visual acuity ____ Dry Eye _____ Eye Pain _____ Itching and redness

3. Ears/Nose/Throat: ____ Ear pain ____ Hoarseness _____ Ringing in the ears _____ Sinus trouble _____ Sore throat

4. Endocrine: _____ Excessive thirst ____ Heat intolerance _____ Thyroid problems

5. Respiratory: _____ Cough ____ Shortness of breath _____ Other (please specify) :_____

6. Breast: _____ Breast Lump _____ Breast Pain _____Breast swelling

7. Cardiovascular: _____ Chest Pain _____ Palpitations _____Other (please specify): _____

8. Gastrointestinal: ___ Bloating ____Abdonimal Pain _____Bowel changes _____Constipation _____Diarrhea ____Nausea _____Rectal Bleeding _____ Vomiting

9. Hematology/ Lymphatic: ____ Anemia ____ Bleeding problems ____Easy bruising _____Swollen glands

10. Genitourinary: _____ Blood in urine _____ Frequent Urination _____ Painful urination _____ Genital Problems

11. Musculoskeletal: ____ Arthritis _____ Back Problems _____ Muscle Aches _____ Painful Joints

12. Skin: _____Dry Skin _____Itching _____ Rash

13. Neurological: _____ Confusion _____ Dizziness _____ Headache _____ Memory loss ___Tingling/Numbness

14. Psychiatric: _____ Anxiety ____ Depressed mood _____ Eating disorder _____Suicidal thoughts

What brings you in today?

_____
_____
_____
_____

**Patient Name (Print)_____ Date: _____**

**Patients Signature:_____ Date:_____**

# Goldin Premier Medicine

Ronald Goldin, M.D., P.A.

## Acknowledgement of receipt of notice of privacy practices

By signing below, I acknowledge that I have reviewed the Notice of Privacy Practices for the company. I understand that copies of the Notice of Privacy Practices are available on the company's website and paper copies are out and available in the office and that I can take one of these copies with me. The Notice of Privacy Practices is required to be provided to me under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, including as it has been amended by the Health Information Technology for Economic and Clinical Health Act (the "HITECH" Act), Title XIII of Division B of the American Recovery and Reinvestment Act of 2009 and any implementing regulations.

Effective Date of Notice: August 1, 2020

Patient: _____ Date: _____
(Print name)

Patient Signature: _____ or

Patient's Representative: _____ Date: _____

Relationship to Patient: _____