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: _____

GOLDIN PREMIER MEDICINE

4215 Burns Road, Suite 240 Palm Beach Gardens, FL 33410
Office: (561) 627-6454 Fax: (561) 625-4374

RECORD RELEASE or REQUEST/ AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient's Name: _____
First Middle Last

Home Address: _____

_____

Date of Birth: _____

SPECIFY INFORMATION TO BE RELEASED OR REQUESTED (CIRCLE WHICH): The information that may be released or requested (circle which) under this Authorization includes:

☐Discharge Summary	☐Progress/Physician Notes	☐X-Ray Report	☐Pathology Report
☐History & Physical	☐Nurses Notes	☐EKG/EMG/EEG Report	☐Consult Report
☐Emergency Report	☐Laboratory Report	☐Operative Report	☐Entire Record

☐Other: _____

Records for the period (dates) from _____ to _____

MY HIGHLY CONFIDENTIAL INFORMATION:

By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box.

Information about mental health
Psychotherapy Notes created by a mental health professional
Information about HIV/AIDS-related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
Information about sexually transmitted diseases
Information about alcohol or drug abuse treatment program services
Information about sexual assault
☐Personal history of child abuse and/or neglect

GOLDIN PREMIER MEDICINE

4215 Burns Road, Suite 240 Palm Beach Gardens, FL 33410
Office: (561) 627-6454 Fax: (561) 625-4374

RECORD RELEASE or REQUEST/ AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

RELEASE Information To/From _____

Name:

_____

Address:

_____

City: State: Zip Code:

_____

Telephone: Fax:

_____

TERM: This Authorization will remain in effect:

From the date of this Authorization until the _____ day of _____, 20_____.
Until Goldin Premier Medicine fulfills this request.
Until the following event occurs: _____
Other: _____

RECORD RELEASE / AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I understand that once **Goldin Premier Medicine** discloses my health information to the recipient, **Goldin Premier Medicine** cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that **Goldin Premier Medicine** may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at **Goldin Premier Medicine**; except, however, if my treatment at **Goldin Premier Medicine** is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case **Goldin Premier Medicine** may refuse to treat me if I do not sign this Authorization.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize **Goldin Premier Medicine** to use or disclose my health information in the manner described above.

Patient Signature _____ **Date** _____

_____ _____ _____

Signature of Authorized Personal Representative Relationship to Patient Date