Stuart M. Goldman D.P.M.

Diplomat, American Board of Podiatric Surgery Fellow, American College of Foot & Ankle Surgeons

Marquis Who's Who in America, Who's Who in Medicine and Health Care

Author, Walking Well Again: Neutralize the Hidden Causes of Pain

Conservative Care of the Foot and Leg

4000 Old Court Rd Suite 301 Pikesville Md. 21208

Office (410) 235-2345 Fax 443-378-8664 HelpForYourFeet.com

Dear Patient,

Welcome to our practice. We hope that we provide relief for your symptoms, and pledge to do our best toward that goal.

Please arrive 10 minutes before your appointment time for paperwork.

Please fill out the attached Patient Information Sheet * BEFORE *** you come in to the office. That will allow us to best process your visit.**

There are additional questionnaires that you may download and fill in before the next visit. Do so only if you feel you have that particular condition.

Those with Growing Pains, Neuropathy, or Arthritis should fill out the LuSSSext

Scale. There is a separate questionnaire for Fibromyalgia.

Please remember to bring in your insurance information and identification at the first visit and every visit thereafter. If you have an HMO that requires a referral, please be sure to bring it with you at the time of the visit.

Bringing these 3 documents, the insurance card, patient identification, and any needed referral is necessary at every visit.

Welcome to our practice.

Stuart M Goldman DPM and Staff.

Welcome to the Office of Dr. Stuart Goldman

GENERAL INFORMATION

Date _____

Patient_____

Address_____

_____ _____ _____

City State Zip

Sex: ☐M ☐F Age _____ Birthdate _____

Shoe size_____ Height _____ Weight _____

☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Patient SS# _____

Occupation _____

Employer/school _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Your Primary Care Doctor _____

Other Physicians: _____

Who referred you to our office? Dr. _____

Patient_____ WWW Beacon Internet

Have you previously had any of the following treatments?

Foot or ankle surgery No Yes _____

_____

For poor leg circulation _____ Circulation Testing

_____ Bypass _____ Angioplasty with or without Stent

For major foot, ankle, or leg injury, pain, or infection No Yes

_____

For peripheral neuropathy or spinal stenosis No Yes

_____

Have you fallen or almost fallen due to balance problems?

No Yes _____

Other history you want to share No Yes _____

_____

YOUR PHONE NUMBERS:

Home _____ _____

Work _____ _____

Cell Phone _____ _____

E Mail : _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship_____

Cell Phone _____

Chief complaints or concerns at this time:

1._____

2._____

3._____

4._____

5._____

Duration of problems: 1. _____

2. _____ 3._____

4. _____ 5._____

Have you been treated for this by a podiatrist, orthopedist or physician? ____No _____Yes

Prior Treatment: _____

_____

Please circle current concerns:

Bunions Hammertoes Tendon Pain

Corns & Calluses Ingrown & Fungus Nails

Skin Growths Neuropathy Burning Feet

Arthritis of the: Foot Ankle Knee Hip

Low Back Shoulder Neck

Flat Feet High Arched Feet

Heel & Arch Pain Diabetic Foot Care

Morton's Neuroma Ulcers or Infections

Walking Limitations from Foot or Leg Pain

Foot or Leg Pain or Cramps at Night

Foot or Leg Pain of Unknown Cause

Difficulty: Standing Sitting Getting Up

Sleeping Bending over to pick things up

Poor Balance Spinal Stenosis Back Pain

Other _____

Medical History ***PLEASE fill out ALL details as best you can.***

ALLERGIES: Please circle ____NONE Local Anesthetic Penicillin Sulfa Tape
Iodine on Skin Aspirin Narcotics Other _____

_____

CURRENT MEDICATIONS List all Medicines and disorders for which you take them.: ____NONE

Medication	Disorder	Medication	Disorder
1._____	_____	2. _____	_____
3._____	_____	4. _____	_____
5._____	_____	6. _____	_____
7._____	_____	8. _____	_____
9._____	_____	10. _____	_____

Do you have Diabetes? __No __Yes Diagnosed in what year? _____

Type 1 Type 2 What (& When) was your last HBA1c? _____ Unknown

Which Doctor helps you manage your Diabetes _____

Complications of Diabetes? No Yes Circle Neuropathy Circulation Problem Foot infection
Heart Problems Kidney Problems Vision Problems Other _____

Are you now or previously diagnosed with any of the following conditions? ___ NONE

Anemia Asthma Poor Vision Glaucoma Kidney Failure Kidney problems
Stomach Ulcers Stomach problems GastroEsophogeal Reflux(GERD) Seizures
Gout Osteoarthritis Rheumatoid Arthritis Fibromyalgia Tuberculosis
TMJ Neck pain Migraines Poor Balance Frequent headaches Liver disease
Depression Anxiety / Nervous Disorder Neuropathy Neurologic problem Spinal Problems
High cholesterol Hypertension Bleeding Disorder Emphysema COPD

Skin Cancers or other Cancer? ☐No ☐Yes _____

Infectious disease ___NONE Circle if you have HIV / Aids Hepatitis type __ Other_____

Cardiac / Vascular Health: Circle if you have had: Heart Attack Heart Surgery Cardiac Disease
Valve Disease Stroke Heart Failure Phlebitis/Blood Clot Venous Disease Peripheral Artery Disease

Explain _____

Social History:

Current Job Student Home maker Retired. Disabled Job _____
Marital Status Married Single Divorced Widowed
Exercise Level **Inactive** **Limited activity** (less than 30 minutes a day)
Moderate (30-60 minutes a day) **Active** (over 60 minutes a day)
General Stress Level **Low** **Moderate** **High**
Smoking Status Never Stopped _____ years ago. Now smoke _____ packs/wk
Alcohol use **Do not drink** **Drink less than 3 drinks/ wk** Drink Socially Heavily
Chewing Tobacco No use Occasional Use Frequent Use
Do you use any recreational drugs None Marijuana Cocaine Narcotics
Other_____
Do You have an advanced directive? Yes No

Please list Foot surgery or joint replacements, and complications with surgery**:** ____NONE

_____ _____

_____ _____

_____ _____

Please list other Major Surgery _____

_____ _____

_____ _____

_____ _____

Preferred Pharmacy _____ _____

Phone Number _____ Fax Number _____

Preferred Lab for Blood Work Quest Lab Corp Other _____

Family History (please circle): ___NONE

Diabetes Father Mother Sibling Complications _____

Amputation _____ Heart Disease _____

Skin Cancer _____ Rheumatoid Arthritis _____

Other _____

Athletic activities in which you participate Walking Running

Swimming Bicycling Sports _____

Any other information you want to share? _____

May we contact your home and leave a message on your answering machine or voice mail, or discuss your medical condition with other residents? YES NO

We contact patients electronically to remind of appointments. How would you prefer to be contacted?

E Mail _____

Cell Phone (text) _____

We ask that you confirm the appointment in order to keep the appointment available.

Please understand that our office policy includes the need for patients to properly cancel appointments, so that we may use the time to provide care for others if you do not keep your appointment.

Patients may be charged a fee for not showing up or cancelling appointments 24 hours in advance.

The fee for the first missed appointment is 20 dollars,
and the following missed appointment fee is 40 dollars.

Chronic failure to keep scheduled appointments will be grounds for dismissal from practice.

Thank you for helping us properly schedule patients by keeping us informed of any changes you need to make.

I hereby acknowledge the above information, and the opportunity to review and receive all HIPAA privacy forms as presented by the staff of Dr. Goldman.

** _____ _____

Patient or representative Date

Is this visit in response to a current or pending automobile accident, traumatic injury, or workers compensation injury? YES NO Name of your attorney: _____

I hereby state that the insurance documents I have provided are accurate and up to date.

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Stuart Goldman all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

*

_____

Responsible Party Signature

_____ _____

Relationship Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Dr. Stuart Goldman for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

*

_____ _____ _____

Responsible party Relationship Date