Practice: DR. GOLDBAUM, DR. KIPP & DR. GABEL

Name: _____ **Date of birth:** _____
E-mail: _____ **SS#:** _____

Sex: ☐ M ☐ F **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home phone: _____ **Cell phone:** _____
Emergency Name: _____ **Emergency Phone:** _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to specify
Race: ☐ Asian ☐ White ☐ America Indian or Alaska Native ☐ Black or African American
☐ Native Hawaiian or other Pacific Islander ☐ Declined to Specify

Primary insurance: _____ **Are you insured?** ☐ Yes ☐ No

Subscriber name: _____ Relationship to insured: ☐ Spouse ☐ Child ☐ Self ☐ Other
Phone #: _____ Sex: ☐ Male ☐ Female DOB: ___/___/_____
Address: _____
Policy ID: _____ Group ID: _____ Employer: _____

Secondary insurance: _____ **Are you insured?** ☐ Yes ☐ No

Subscriber name: _____ Relationship to insured: ☐ Spouse ☐ Child ☐ Self ☐ Other
Phone #: _____ Sex: ☐ Male ☐ Female DOB: ___/___/_____
Address: _____
Policy ID: _____ Group ID: _____ Employer: _____

Pharmacy Name: _____ **Phone:** _____
Address: _____ City, State, Zip: _____

Primary Care Physician: _____ **Phone:** _____ **Date Last Seen:** _____
Address: _____ City, State, Zip: _____

Referring Physician: _____ **Phone:** _____ **Date Last Seen:** _____
Address: _____ City, State, Zip: _____

Privacy Information Preferences

Do you want to be exempt from public reporting? ☐ Yes ☐ No
Can we send mail to the address on file? ☐ Yes ☐ No
Can we call the phone number on file? ☐ Yes ☐ No
Can we leave voicemails on your machine? ☐ Yes ☐ No
Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? ☐ Yes ☐ No

Who can we leave messages with? ☐ Wife ☐ Husband ☐ Son ☐ Other: _____
Name(s): _____

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above

Signature: _____ **Date:** _____

How did you find our practice? ☐ Physician ☐ Internet ☐ Family Member ☐ Friend ☐ Other

What is the reason for your visit today? _____

_____ **Result of accident or work injury?** ☐ Yes ☐ No

How long has this bothered you? 1 2 3 4 5 6 7 ☐ days ☐ weeks ☐ months ☐ years

What treatments have you tried & have they been effective? _____

On a scale of 1-10 (1 being no pain & 10 being the worst) what is your level of pain? ___/10

The pain quality is: ☐ burning ☐ constant ☐ dull ☐ sharp ☐ shooting ☐ throbbing ☐ tingling ☐ other
Are your symptoms getting… ☐ better gradually ☐ better rapidly ☐ worse gradually ☐ worse rapidly

What improves your symptoms? ☐ rest ☐ ice ☐ heat ☐ mortin/aleve ☐ other _____

What makes your symptoms worse? ☐ activity ☐ other _____

Do you have any of the following?

☐ Ankle sprain	☐ Arch pain	☐ Athlete's foot	☐ Broken ankle	☐ Broken foot bone
☐ Bunions	☐ Burning in feet	☐ Corns/calluses	☐ Cramps in feet	☐ Cramps in legs
☐ Enlarged veins	☐ Flat feet	☐ Foot numbness	☐ Foot ulcers	☐ Fungal nails
☐ High arch feet	☐ Heel pain	☐ Hammer toes	☐ Ingrown nails	☐ In-toeing
☐ Knee pain	☐ Leg ulcers	☐ Lower back pain	☐ Rash on feet	☐ Swelling in ankles
☐ Swelling in feet	☐ Swelling in legs	☐ Tingling in feet	☐ Loss of sensation in feet	

Have you ever worn orthotics? ☐ Yes ☐ No
Does your foot pain limit your desired activity? ☐ Yes ☐ No
Are your first steps out of bed in the morning painful? ☐ Yes ☐ No
Have you ever had any other foot problems? ☐ Yes ☐ No

Have you fallen in the past 12 months? ☐ Yes ☐ No **Were you injured from the fall?** ☐ Yes ☐ No

Current Medications:
☐ No known medications

Name: _____ Dose: _____
Name: _____ Dose: _____
Name: _____ Dose: _____
Name: _____ Dose: _____
Name: _____ Dose: _____
Name: _____ Dose: _____
Name: _____ Dose: _____
Name: _____ Dose: _____
Name: _____ Dose: _____
Name: _____ Dose: _____

Use the back of this form if more room is needed

Allergies:
☐ No known allergies ☐ No known drug allergies

Name: _____ Reaction: _____
Name: _____ Reaction: _____
Name: _____ Reaction: _____
Name: _____ Reaction: _____
Name: _____ Reaction: _____
Name: _____ Reaction: _____
Name: _____ Reaction: _____
Name: _____ Reaction: _____
Name: _____ Reaction: _____
Name: _____ Reaction: _____

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. (Assignment of benefits): I authorize payment of medical benefits to the practice named above. (Release of information): I authorize the release of any medical information necessary to process this claim. (HIPPA Privacy): I acknowledge that I received my HIPPA Privacy Practice. (Medication History): I authorize the doctor's office to retrieve my medication history.

Signature: _____ **Date:** _____

Medical History:

☐ Alcoholism ☐ Circulation problems
☐ Blood disorders ☐ Breathing issues
☐ Asthma ☐ Heart murmur
☐ Anxiety disorder ☐ Mental illness
☐ High cholesterol ☐ Hepatitis
☐ High blood pressure
☐ Diabetes (type 1, type 2)

☐ Musculoskeletal ☐ Allergies ☐ Heart disease
☐ Liver ☐ Sleep apnea ☐ Gout
☐ Stomach/bowel ☐ Depression ☐ Cancer
☐ Kidney disease ☐ Blood clot ☐ Stroke
☐ Skin disorders ☐ HIV ☐ CVA

☐ Neuropathy (specify) _____
☐ Arthritis (specify) _____

☐ Thyroid disease (specify) _____
☐ Other (specify) _____

Are you pregnant? ☐Yes ☐ No **Are you nursing?** ☐Yes ☐ No

Family History: Is there any family history (*blood relative*) of: (*Please indicate family member*)

☐ Alzheimer's _____
☐ Arthritis _____
☐ Bleeding disorders _____
☐ Blood clot _____
☐ Cancer _____
☐ Cataracts _____
☐ Circulation problems _____
☐ Other: _____

☐ Depression _____
☐ Diabetes _____
☐ Emphysema _____
☐ Heart disease _____
☐ High blood pressure _____
☐ Neurological _____
☐ Strokes _____

Surgical History:

☐ None ☐ Appendectomy ☐ C-section ☐ Angioplasty ☐ Bypass ☐ Cataracts ☐ Cholecytectomy
Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? ☐ Yes ☐ No
If yes, please describe: _____

Do you have any artificial joints? ☐ Yes (where? _____) ☐ No
Do you have an artificial heart valve? ☐ Yes ☐ No

Social History:

Do you smoke?
Yes: ☐ Current everyday smoker ☐ Current some day smoker
If yes, how many packs a day? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 For how long? _____
No: ☐ Former ☐ Never

Do you drink alcohol? ☐ Yes, everyday (5-7 times per week) ☐ Yes, occasionally/socially ☐ No/rarely

Substance Abuse: ☐ Yes, I have a **current** substance abuse problem. Please specify: _____
☐ Yes, I've had a **past** substance abuse problem. Please specify: _____
☐ No, I've never had a substance abuse problem

What is your occupation: _____ Does it involve mostly ☐ standing or ☐ sitting

Do you exercise regularly? ☐ No, I do not exercise regularly ☐ Yes, I do the following regular exercise:
_____

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Signature: _____ **Date:** _____

podiatry

MEDICAL & SURGICAL MANAGEMENT OF THE LEG, ANKLE AND FOOT

PLEASE ANSWER ALL QUESTIONS:

Patient History

SYSTEM REVIEWS (*Please circle yes or no for each item*)

GENERAL SYMPTOMS

Good general health lately	YES	NO
Recent weight change	YES	NO
Fever	YES	NO
Fatigue	YES	NO
Headaches	YES	NO

EYES

Blurred or double vision	YES	NO
Glaucoma	YES	NO
Wears glasses or contacts	YES	NO
Cataracts	YES	NO

EARS/NOSE/THROAT

Hearing loss or ringing	YES	NO
Earaches or drainage	YES	NO
Chronic sinus problems or rhinitis	YES	NO
Nose bleeds	YES	NO
Mouth sores	YES	NO
Sore throat or voice change	YES	NO
Swollen glands in neck	YES	NO

CARDIOVASCULAR

Chest pain	YES	NO
Swelling of feet, ankles or hands	YES	NO
Pacemaker	YES	NO

RESPIRATORY

Chronic or frequent coughs	YES	NO
Spitting up blood	YES	NO
Shortness of breath	YES	NO
Asthma or wheezing	YES	NO
Emphysema	YES	NO
Tuberculosis	YES	NO

GENITOURINARY

Frequent urination	YES	NO
Burning/painful urination	YES	NO
Blood in urine	YES	NO
Incontinence/dribbling	YES	NO
Female – irregular periods	YES	NO
Female – pregnancies	YES	NO
Kidney failure	YES	NO
Dialysis	YES	NO

MUSCULOSKELETAL

Joint pain	YES	NO
Joint stiffness	YES	NO
Weakness of muscles or joints	YES	NO
Back pain	YES	NO
Cold extremities	YES	NO
Difficulty walking	YES	NO
Arthritis	YES	NO

INTEGUMENTARY (skin)

Rash or itching	YES	NO
Varicose veins	YES	NO
Change in mole	YES	NO

NEUROLOGICAL

Frequent/recurring headaches	YES	NO
Light headedness or dizziness	YES	NO
Convulsions or seizures	YES	NO
Poor sensation in feet	YES	NO
Paralysis	YES	NO
Stroke	YES	NO

PSYCHIATRIC

Memory loss or confusion	YES	NO
Depression	YES	NO
Claustrophobia	YES	NO

ENDOCRINE

Glandular or hormone problems	YES	NO
Thyroid disease	YES	NO
Diabetes	YES	NO
Excessive thirst or urination	YES	NO
Heat or cold intolerance	YES	NO

HEMOTOLOGIC/LYMPHATIC

Slow to heal after cuts	YES	NO
Bleeding or bruising tendency	YES	NO
Anemia	YES	NO
Phlebitis	YES	NO

GASTROINTESTINAL

Loss of appetite	YES	NO
Nausea or vomiting	YES	NO
Frequent diarrhea	YES	NO
Painful bowel movements	YES	NO
Blood in stool	YES	NO

podiatry

MEDICAL & SURGICAL MANAGEMENT OF THE LEG, ANKLE AND FOOT

SOUTH COUNTY PROFESSIONAL CENTER
16244 S. MILITAY TRAIL
STE. 290
DELRAY BEACH, FL 33484
(561) 499-0033

NAME: _____

This is to inform you that due to circumstances beyond our control, the treatment room doors may be partially open at times during our practice, therapy, and treatment. General advice and conversation may be overheard by others in this area. If you wish to have your door closed, please notify us. We strive to make all of our patients as comfortable as possible.

If you have concerns, please let us know.

PATIENT SIGNATURE: _____

DATE: _____

DIPLOMATE, AMERICAN BOARD OF MUTIPLE SPECIALTIES IN PODIATRY
BOARD CERTIFIED IN PRIMARY PODIATRY, PODIATRIC SURGERY, WOUND CARE,
LIMB SALVAGE AND PRESERVATION
FAX: (561) 499-2806
WWW.DELRAYBEACHPODIATRY.COM

podiatry

MEDICAL & SURGICAL MANAGEMENT OF THE LEG, ANKLE AND FOOT

SOUTH COUNTY PROFESSIONAL CENTER
16244 S. MILITAY TRAIL
STE. 290
DELRAY BEACH, FL 33484
(561) 499-0033

NOTICE OF PATIENT RESPONSIBILITY POLICY:

Thank you for choosing Dr. Ian Goldbaum as your podiatric physician. We ask that you read and sign this form to acknowledge your understanding of our patient responsibility policy. Dr. Ian Goldbaum and his staff will make every effort to determine patient responsibility prior to treatment. When applicable, payment is due at time of service. For your convenience we accept most major credit cards and persona checks. Payment plans are also available.

SERVICES PROVIDED: I acknowledge for today's visit that I will assume full financial responsibility for services rendered to me, if my insurance carrier denies or does not cover my claim for these services.

MEDICAL NECESSITY: If my insurance determines that medical services and/or materials are not covered, I acknowledge that I have been notified and will assume full responsibility for the service (s) and materials rendered.

COPAYS: I understand that I am responsible to pay all co-payments at the time of service, prior to leaving.

DEDUCTIBLES: If my insurance determines that I have not met my deductible, I understand that I will be fully responsible for payment in a timely manner, no more than 30 days after I have been notified by insurance and/or provider.

AGREEMENT TO PAY: I have received a copy of this form and I have been notified on the above by this provider that I am financially responsible for all services and materials rendered if my insurance does not cover or denies payment for a service or material.

Date: _____

Guarantor/Patient Signature: _____

Patient Name (Printed): _____

Witness: _____

DIPLOMATE, AMERICAN BOARD OF MUTIPLE SPECIALTIES IN PODIATRY
BOARD CERTIFIED IN PRIMARY PODIATRY, PODIATRIC SURGERY, WOUND CARE,
LIMB SALVAGE AND PRESERVATION
FAX: (561) 499-2806
WWW.DELRAYBEACHPODIATRY.COM

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, _____, have received a copy of this office's notice of privacy practices.

Name: _____
Signature: _____
Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our notice of privacy practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other: _____

Notice of Privacy Practice:

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY:

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on Nov. 1 2013 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations; for example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the patient rights of this notice. We may disclose your health information to a family member, friend or any other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of armed forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

PATIENT RIGHTS

Access: You have the right to look of or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your heath information. You may obtain a form to request access by using the contact information listed of the end of this notice. We will charge you a reasonable cost-based fee for expenses, such as copies and staff time. You may also request access by sending us a letter to the address of the end of this notice. If you request copies, we will charge you $1.00 for each page and $____ per hour of staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request on alternate format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed of the end of this notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last six (6) years, but not before April 14, 2003. If you request this accounting more than once in a twelve (12) month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form.

QUESTIONS AND COMPTAINTS

If you want more information about our privacy practices or hove questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us by using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Deportment of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U. S. Department of Health and Human Services.

Contact Office: **Ian S. Goldbaum, D.P.M. P.A.**

Address: **16244 S. Military Trail, Ste. 290 Delray Beach, Florida, 33484**

Telephone: **(561) 499-0033** Fax: **(561) 499-2806**

Email: Goldbaumpodiatry@aol.com