Neal D. Goldman, M.D.

Facial Plastic and Reconstructive Surgery

PATIENT INFORMATION Please Print

Today's date: _____

Title: Dr Mr Mrs Ms First name: _____ Last name: _____ Middle initial: ____

Address: _____

City: _____ State: _____ Zip: _____ Gender: M F

Date of Birth: _____ Age: _____ SS# _____ Marital Status: M S W D

Drivers License number (if a minor, please use guarantor) Issuing State: _____ Number: _____

Phone (H): _____ Phone (W): _____ ext. _____ Phone (C): _____

Preferred method of contact: Home Work Cell

Education: _____ Occupation: _____ Race: _____

Pharmacy: _____ Pharmacy Address: _____

Pharmacy Phone: _____

PHYSICIAN INFORMATION

Referring Physician: _____ Phone: _____

Address: _____

Primary Care Physician: _____ Phone: _____

Address: _____

Other Physician: _____ Phone: _____

Address: _____

HOW DID YOU HEAR ABOUT US?

- ❑ I am a former patient of Dr. Goldman
- ❑ Physician (please list above)
- ❑ Friend
- ❑ Another Patient – Who: _____
- ❑ Website
- ❑ Newspaper – Which one: _____
- ❑ Seminar
- ❑ Magazine – Which one: _____
- ❑ Hospital – Which one: _____
- ❑ Other: _____

AUTHORIZATIONS

I authorize Neal Goldman, M.D.to disclose complete information concerning medical finding and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment, to those individuals who, in Neal Goldman, M.D. determination, are required to receive such information for the purpose of medical treatment, medical quality assurance, peer review, and *if applicable* to process the insurance claim for services rendered.

☐I consent to the release of my protected health information to the physicians listed above and other health care providers.

☐I do not wish my protect health information to be released to other medical health care providers.

_____ _____

Patient Signature (Guarantor) Date/Time

Neal D. Goldman, M.D.

GUARANTOR INFORMATION

☐ CHECK HERE IF SAME AS PATIENT INFORMATION *(The guarantor is the responsible party for insurance payments and charges.)*

Guarantor Name: _____ Date of Birth: _____SSN#: _____

Address: _____

Phone:_____

PRIMARY INSURANCE INFORMATION

Policy Holder's Name: _____ Date of Birth: _____

Relationship to Patient: _____ Phone: _____

Insurance Company: _____ Policy ID #: _____ Group #: _____

SECONDARY INSURANCE INFORMATION☐ CHECK HERE, IF NONE

Policy Holder's Name: _____ Date of Birth: _____

Relationship to Patient: _____ Phone: _____

Insurance Company: _____ Policy ID #: _____ Group #: _____

Please note we will need to make a copy of your driver's license or state issued photo ID for your record.

FINANCIAL POLICY

We are committed to meeting your healthcare needs. Our goal is to keep your financial arrangements as simple as possible. We ask that you adhere to the following policy:

- I understand that health insurance is a contract between me and my insurance carrier. It is my responsibility to understand my insurance policy and to provide Neal D. Goldman, M.D. with current insurance information at the time of my visit.
- I authorize the release of medical information necessary to process my insurance claim and I assign insurance benefits to ***Goldman Center for Facial Plastic Surgery*** for services provided to me by Neal D. Goldman, M.D.
- I understand that co-pays are due at the time of service, as required by my insurance company.
- I agree that I will be responsible for balances applied to my account that are not covered by my health insurance plan.
- In the event my account is turned over to an outside collection agency, I agree that I will be responsible for all attorney fees, court costs, etc.
- I understand that my account will be charged $25 when a check I presented for payment is returned and marked "non-sufficient funds" (NSF). Returned checks over $500 will be assessed a fee of 5% of the amount of the check.
- Form Fees: I understand that I may be charged a fee as set by the state of North Carolina for any forms or letters I request. This fee covers administrative expenses related to physician/staff time associated with the forms/letters.
- I understand that billing statements, if applicable, will be mailed to me by a third party medical billing company.
- If I plan to self-pay (privately pay) for services rendered by Neal D. Goldman, M.D., I understand that payment in full is expected at the time of service for office visits and three weeks before surgical procedures.
- If I self-pay for a surgery, procedure or office visit, regardless if it is for reconstructive or cosmetic services, I agree not to attempt to later bill my insurance company for Neal D. Goldman, M.D.'s fees.

I acknowledge that I have read the above financial policy, and I agree to read this document and comply with the terms set forth for services rendered by Neal D. Goldman, M.D.

_____ _____

Patient Signature (Guarantor) Date/Time

Neal D. Goldman, M.D.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

H I P A A

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996 (a federal law). Of significant concern to healthcare organizations is the Administrative Simplification section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals, employers
- Healthcare Transaction & Code Sets for transmitting data electronically
- Privacy regulations over disclosure and use of health information
- Security regulations over protections of electronic health information

I, _____have been informed that a copy of our offices Notice of Privacy Practices is posted in the waiting room(s). A copy of this Notice will be furnished to me upon my request.

_____ _____

Patient Signature (Guarantor) Date/Time

EMERGENCY CONTACT INFORMATION:

Emergency Contact:_____ Relationship to patient:_____

Phone (cell):_____ Phone (work)_____ext._____ Phone(home):_____

Preferred method of contact: ☐ Home ☐ Work ☐ Cell

Please list names of people we can discuss your medical care with:

Spouse Name _____ yes____ no____

Parent Name _____ yes____ no____

Other Name _____ yes____ no____

Please give name and relationship such as boyfriend, sister, etc.

Anytime we receive a call from yourself or those that you have listed as individual(s) that may discuss your medical or skin care records they will have to supply a unique identifier that confirms identity. Please list your unique identifier as either the last four digits of your social security number or your mother's maiden name:

Unique identifier: (select one)

Last four digits of SS#_____

Mother's maiden name_____

Pet _____

Neal D. Goldman, M.D.

PHOTOS

I, _____ (print full name), understand that photographs will be taken periodically throughout my treatments and/or procedures. These photographs will be used to monitor progress and other factors.

I understand that these photographs may be used with correspondence to insurance companies for authorizations on my behalf and for communication with referring physicians and other health care providers.

_____ _____

Patient Signature (Guarantor) Date/Time

Email Me

☐ Yes! I want to be included in future emails from Dr. Goldman that include newsletters, special offers, events, and news.

Date: _____

Name: _____

Email Address: _____

Contact Number: _____

Dr. Goldman will not sell or use your email address for any other purposes other than to send marketing information from our office to your email address listed above. You can request to be removed from the approval list at any time.

Neal D. Goldman, M.D.

MEDICAL HISTORY

NAME	DOB	DATE

CHIEF COMPLAINT (Reason you came to see Dr. Goldman)		
BRIEF HISTORY OF PRESENT ILLNESS/CONDITION		
LIST WHEN AND HOW YOUR CONDITION STARTED		
PAIN LEVEL 0 1 2 3 4 5 6 7 8 9 10	SEVERITY OF PAIN ☐ MILD ☐ MODERATE ☐ SEVERE	GRADE OF PAIN ☐ CONSTANT ☐ INTERMITTENT
DURATION OF COMPLAINT	WHAT HELPS THE PROBLEM	WHAT EXACERBATES THE PROBLEM
ASSOCIATED SYMPTOMS		

CURRENT MEDICATIONS

☐ None ☐ See List (Please list dosage and schedule)	
1.	5.
2.	6.
3.	7.
4.	8.
NON-PRESCRIPTION DRUGS ASPIRIN: ☐ YES ☐ NO IBUPROFEN: ☐ YES ☐ NO HOMEOPATHIC: ☐ YES ☐ NO SBE PROPHYLAXIS: ☐ YES ☐ NO	

ALLERGIES TO MEDICATIONS/MEDICAL SUPPLIES ☐ No Known Diagnosed Allergies
☐ Penicillin ☐ Lidocaine ☐ Latex ☐ Tape ☐ Other:_____

PAST MEDICAL HISTORY ☐NONE

BLEEDING TENDENCY	☐ YES ☐ NO	HEART MURMUR	☐ YES ☐ NO	LUNG DISEASE	☐ YES ☐ NO
DIABETES	☐ YES ☐ NO	HIGH BLOOD PRESSURE	☐ YES ☐ NO	MENTAL ILLNESS	☐ YES ☐ NO
EYE PROBLEMS	☐ YES ☐ NO	HISTORY DVT/PE	☐ YES ☐ NO	NEUROLOGIC DISEASE	☐ YES ☐ NO
HEART DISEASE	☐ YES ☐ NO	HIV/ AIDS	☐ YES ☐ NO	SKIN CANCER	☐ YES ☐ NO
HEART ATTACK	☐ YES ☐ NO	KIDNEY DISEASE	☐ YES ☐ NO	OTHER CANCER	☐ YES ☐ NO
STROKE	☐ YES ☐ NO	LIVER DISEASE	☐ YES ☐ NO	THYROID DISEASE	☐ YES ☐ NO
SLEEP APNEA	☐ YES ☐ NO	HIGH CHOLESTEROL	☐ YES ☐ NO		
OTHER/DETAILS FROM ANY YES ABOVE					

SURGICAL HISTORY(Please list dates) ☐NONE

SEPTOPLASTY	☐ YES ☐ NO		APPENDIX	☐ YES ☐ NO	
RHINOPLASTY	☐ YES ☐ NO		GALL BLADDER	☐ YES ☐ NO	
TURBINECTOMY	☐ YES ☐ NO		HYSTERECTOMY	☐ YES ☐ NO	
FACELIFT	☐ YES ☐ NO		TONSILS	☐ YES ☐ NO	
EYE SURGERY	☐ YES ☐ NO		EAR SURGERY	☐ YES ☐ NO	
SKIN RESURFACING/LASER	☐ YES ☐ NO		NECK SURGERY	☐ YES ☐ NO	
OTHER SURGERY	☐ YES ☐ NO	Explain:			
ANESTHESIA PROBLEMS	☐ YES ☐ NO	Explain:			
SURGICAL PROBLEMS	☐ YES ☐ NO	Explain:			

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SOCIAL HISTORY

OCCUPATION	MARITAL STATUS
SMOKING ☐ NO ☐ YES Pack per Day _____ How Long _____Quit Date _____	
ALCOHOL USE: ☐ NONE ☐ RARE ☐ OCCASIONALLY ☐ FREQUENT	HISTORY of ALCOHOL ABUSE: ☐ YES ☐ NO
RECREATIONAL DRUG USE ☐NONE ☐ MARIJUANA ☐ COCAINE ☐ HEROIN ☐ PAIN MEDS ☐ METH	

FAMILY HISTORY **(indicate which Blood Relative)** ☐NONE

SKIN CANCER	DIABETES	STROKE
OTHER CANCER	HEART DISEASE	ABNORMAL BLEEDING
MALIGNANT HYPERTHERMIA	OTHER	

If you were unprotected and exposed to sun, would you ☐Never Burn ☐Occasionally Burn ☐Always Burn
If you were unprotected and exposed to sun, would you ☐Never Tan ☐Occasionally Tan ☐Always Tan

Height: _____ Current Weight: _____ pounds
Recent weight gain or loss? ☐ Yes ☐ No Weight gain _____ pounds or weight loss _____ pounds
Accutane in the past ☐ Yes ☐ No If yes, how long did you take? _____ When did you stop? _____
Steroids in the last 12 months: ☐ Yes ☐ No
Do you take a Blood Thinner(s)? ☐ Yes ☐ No If yes, which one(s):_____

REVIEW OF SYSTEMS

Fever / Chills:	☐ Yes ☐ No	Bleeding Tendency:	☐ Yes ☐ No
Stomach Ulcer:	☐ Yes ☐ No	Difficulty Swallowing:	☐ Yes ☐ No
Night Sweats:	☐ Yes ☐ No	Allergies:	☐ Yes ☐ No
Heart burn / Reflux:	☐ Yes ☐ No	Speech Changes:	☐ Yes ☐ No
Vision Loss:	☐ Yes ☐ No	Enlarged Thyroid/Goiter:	☐ Yes ☐ No
Back/Neck Pain:	☐ Yes ☐ No	High Blood Pressure:	☐ Yes ☐ No
Double Vision:	☐ Yes ☐ No	Enlarged Gland/Node:	☐ Yes ☐ No
Nerve Pain/Paralysis:	☐ Yes ☐ No	Chest Pain or Tightness:	☐ Yes ☐ No
Dry Eye:	☐ Yes ☐ No	Frequent Sunburns:	☐ Yes ☐ No
Facial Weakness:	☐ Yes ☐ No	Asthma/Breathing Problems:	☐ Yes ☐ No
Nasal Obstruction:	☐ Yes ☐ No	Scarring/ Keloids:	☐ Yes ☐ No
Depression/Anxiety:	☐ Yes ☐ No	Shortness of Breath:	☐ Yes ☐ No
Difficulty Urinating:	☐ Yes ☐ No	Renal Failure/Dialysis:	☐ Yes ☐ No
Drug or Alcohol Dependency	☐ Yes ☐ No	Breast Mass/Lump:	☐ Yes ☐ No
Sinus Problems:	☐ Yes ☐ No	Hepatitis/Jaundice:	☐ Yes ☐ No

FEMALE PATIENTS

Are you currently pregnant?	☐ Yes ☐ No	Are you Planning Pregnancy?	☐ Yes ☐ No
Do you take birth control pills?	☐ Yes ☐ No	Are you currently breast-feeding?	☐ Yes ☐ No

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Dr. Goldman's Use:

Reviewed w/ Patient: _____Date/Time:_____ Reviewed w/ Patient: _____Date/Time:_____

Reviewed w/ Patient: _____Date/Time:_____ Reviewed w/ Patient: _____Date/Time:_____

Reviewed w/ Patient: _____Date/Time:_____ Reviewed w/ Patient: _____Date/Time:_____

Reviewed w/ Patient: _____Date/Time:_____ Reviewed w/ Patient: _____Date/Time:_____

Reviewed w/ Patient: _____Date/Time:_____ Reviewed w/ Patient: _____Date/Time:_____