CHARLES B. GOODWIN, MD
635 Madison Avenue - 7th Floor
New York, NY 10022
Phone: 212-857-4600 | Fax: 212-759-1685
www.DrCharlesGoodwin.com

We appreciate your cooperation in filling out this form.

Please give the Receptionist your insurance card to copy for our record

PATIENT INFORMATION

Patient name: _____

Home address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Email Address: _____ Cell Phone: _____

Date of Birth: _____ Age: _____

Social Security #: _____

Occupation: _____

Employer's name: _____

Employer's address: _____

_____

Person to notify in case of emergency: _____

Relation to patient: Spouse Mother Father Other_____

Phone: _____

REFERRAL SOURCE

Patient Referred by: Physician Friend Other _____

Referring Physician: _____

Address: _____

Phone: _____

Is this a second surgical opinion? Yes ☐ No ☐

Would Like a report sent to your Referring Physician: Yes ☐ No ☐

Managed Care Patients:

Is this your Primary care Physician: Yes ☐ No ☐ If No, please provide us with the following:

Primary Care Physician: _____

Address: _____

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PRIMARY INSURANCE

Policyholder is: Patient Spouse Parent Managed Care? Yes ☐ No ☐

Policyholder name: _____ DOB _____

Insurance company: _____

Insurance address: _____

_____ Phone: _____

Certificate number: _____ Group: _____ Plan: _____

SECONDARY INSURANCE

Policyholder is: Patient Spouse Parent Managed Care? Yes ☐ No ☐

Policyholder name: _____ DOB _____

Home address: _____

_____

Home Phone: _____ Work Phone: _____

Social Security #: _____ Occupation: _____

Employer's name: _____

Employer's address: _____

Insurance company: _____

Insurance address: _____

_____ Phone # _____

Certificate number: _____ Group: _____ Plan: _____

COMPENSATION / NO FAULT INFORMATION (Work Related or Motor Vehicle accident)

Carrier Name: _____

Carrier Address: _____

City, State, Zip: _____ Phone # _____

Contact Person: _____

WCB Case # _____ Carrier Case # _____

Date of Accident: _____ Comp or No Fault

Comments: _____

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PATIENT MEDICAL HISTORY

Allergies: _____

Current Medications: _____

_____

Please circle any of the following conditions you have now, or have has in the past:

Bleeding Problems	Cancer	Tuberculosis	Kidney Disease	Stomach Ulcer
High Blood Pressure	Goiter	Skin Problems	Heart Disease	Rheumatic Fever
Thyroid Disease	Diabetes	Gout	Bladder Disease	Rheumatoid Arthritis

List prior surgeries of any kind including dates and complications:

_____

_____

_____

Please describe, with dates, any serious injuries:

_____

_____

_____

Please note the reason for today's visit:

_____

_____

Side of body affected: Right ☐ Left ☐ Both ☐ I am Righthanded ☐ I am Lefthanded ☐

Please provide the name, address, and date of visit for previous treatment of this problem:

_____

_____

Please provide the date of injury, or the date you first noticed this problem:

_____

Please provide any additional medical information relevant to your current problem:

_____

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Patient's Name _____

(First) (MI) (Last)

Claims Authorization

I hereby authorize any physician, health care practitioner, hospital, clinic, or other medical facility to furnish any and all records, medical history, services rendered or treatment given to me or any dependent for purposes of review, investigation or evaluation of any claim submitted to my health insurance carrier(s). I also authorize my insurance carrier(s) to disclose to a hospital or health care service plan, self-insurer, or other insurer any medical information obtained if such disclosure is necessary to allow the processing of any claim. If my coverage is under a group contract held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or audit. This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with my insurer(s) including a reasonable time thereafter, until its final consummation. This authorization shall be binding upon me, my dependents, and our heirs, executors and administrators.

Assignment of Benefits – Private and Federal (Medicare)

I authorize payments of medical and surgical benefits, including Medicare benefits; to be made either to me or on my behalf to this office for any services furnished by my physician(s) to me. 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 payable for related services.

Litigation Disclaimer

It is understood and agreed that I am requesting examination and treatment for medical purposes only, and not in connection with pending or proposed litigation. Should such litigation arise, it is further understood and agreed that the treating physician will not participate in any way in litigation except to provide a true and accurate copy of any medical record and X ray in the possession and control of this office, pursuant to receipt of a properly notarized consent for medical information, requested by the patient or his/her legal guardian, and upon payment of the usual fee.

Radiological films

Radiology films are the property of the patient. Charles B. Goodwin, MD, as a courtesy, will store all films. We will release films only to the patient or representative of the patient. Patient's films will not be released to an attorney.

Patient/Relative or Guardian: _____

(Signature)

_____ _____

(Date) **(Print Name)**

_____ _____

(Acct. #) **(Relationship, if signed by person other than patient)**

Photocopy or fax of this form shall be considered as effective and valid as the original