

**Jeffrey E. Goldberg, M.D., P.C.**  
4245 Johns Creek Parkway, Suite D Suwanee, GA 30024  
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welisten@jgoldbergmd.com

DATE \_\_\_\_\_

**PATIENT REGISTRATION FORM**  
***PLEASE COMPLETE THIS FORM IN ITS ENTIRETY***

PATIENT'S LEGAL NAME \_\_\_\_\_ DOB \_\_\_\_\_ SEX \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ EMAIL \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PARENT'S NAME (if pediatric patient) \_\_\_\_\_

PRIMARY CARE PHYSICIAN \_\_\_\_\_ PHARMACY & PHONE \_\_\_\_\_

REFERRED BY:  PRIMARY CARE PHYSICIAN  FRIEND (name) \_\_\_\_\_

**PRIMARY INSURANCE/ RESPONSIBLE PARTY** (information regarding **adult** responsible for payment)

CARRIER \_\_\_\_\_ ID# \_\_\_\_\_ GROUP # \_\_\_\_\_

INSURED (ADULT) NAME \_\_\_\_\_ DOB \_\_\_\_\_

INSURED SS# \_\_\_\_\_ RELATION TO PATIENT \_\_\_\_\_

ADDRESS (IF DIFFERENT) \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

**SECONDARY INSURANCE**

CARRIER \_\_\_\_\_ ID# \_\_\_\_\_ GROUP # \_\_\_\_\_

INSURED NAME \_\_\_\_\_ DOB \_\_\_\_\_

INSURED SS# \_\_\_\_\_ RELATION TO PATIENT \_\_\_\_\_

ADDRESS (IF DIFFERENT) \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

**EMERGENCY INFORMATION**

CONTACT NAME \_\_\_\_\_ RELATION TO PATIENT \_\_\_\_\_

PHONE NUMBERS \_\_\_\_\_

ADDRESS (IF KNOWN) \_\_\_\_\_

**CONSENT TO RELEASE MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS**

I hereby consent to the release of medical information to any insurance carrier, other treating physician office, or other party that I may direct by the staff of Jeffrey E. Goldberg, M.D., P.C. I further direct that all payments from insurance carriers be assigned and sent to Jeffrey E. Goldberg, M.D., P.C. for services rendered. Any amount not paid by insurance must be paid by the patient or Responsible Party.

**CONSENT TO MEDICAL TREATMENT**

I hereby consent to the medical treatment for the above mentioned patient by the medical staff of Jeffrey E. Goldberg, M.D., P.C. I further state that I am duly authorized under law to consent to the medical treatment obtained.

AUTHORIZED SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PRINT NAME \_\_\_\_\_

## Procedures Performed in the Office

Patients are referred to our office by primary care physicians who often do not have the equipment or specialized training required to perform many of the procedures common to this practice. These procedures are often the best way, or only way, diagnose and/or treat the patient's problem.

Most insurance plans hold the patient responsible for meeting their deductible before a procedure is covered. These procedures are not considered part of the office visit. Some of the most commonly performed office procedures to which your deductible may apply are listed below:

**Laryngoscopy or nasal endoscopy** (examining the inside of the throat or nose with a lighted scope)

**Audiometry** (includes initial and follow-up hearing tests, measuring ear pressure, testing speech development and speech comprehension, and tests to diagnose dizziness or vertigo)

**Binocular microscopy** (looking inside the ear with a microscope)

**Foreign body removal** from the ear or nose

**Control of nosebleed**

**Removal of wax** and debris from the ears

This list does not include all procedures, tests, or office surgeries that may require that your deductible be satisfied before insurance coverage applies. If a deductible applies, or insurance does not fully pay for the procedure, or if a procedure, test, or surgery is denied or not covered, the patient or responsible party will be responsible for the cost of the procedure.

I have read and understand that I may have financial responsibility for all or some of the costs I may incur for office procedures or tests.

\_\_\_\_\_  
Patient or responsible party

\_\_\_\_\_  
Date



**This consent is for a procedure commonly performed on many patients with nasal, sinus, or throat problems. We ask all patients to sign this consent in order to minimize your wait time if this procedure is necessary.**

**Signing this consent DOES NOT mean that you must or that you will have this procedure. Endoscopy is only performed as Dr. Goldberg deems necessary, on a case by case basis.**

**If you choose not to have this procedure performed, CONSENT MAY BE REVOKED AT ANY TIME.**

### **Consent for Endoscopy**

If the patient is experiencing problems with sinuses, nose, or throat, Dr. Goldberg, his physician assistant or nurse practitioner, may need to perform an examination in the office using a fiberoptic endoscope. Even though this is a minor procedure performed in the office, many insurance plans do NOT consider this to be a routine component of the office visit. Deductible and co-insurance may apply to this procedure.

The lighted scope will allow Dr. Goldberg or his assistants to see if there is any abnormality within the nose, sinuses or throat that might be contributing to the patient's problem. Endoscopic examination allows Dr. Goldberg or his assistants to see areas not normally visible without use of the endoscope. Refusal to undergo endoscopic examination limits the doctor's ability to diagnose minor, serious, or life-threatening problems, and to initiate appropriate treatment.

The procedure is generally well tolerated with minimal discomfort. The nose is sprayed with a mixture of Afrin, a topical decongestant, to shrink the nasal membranes; and Lidocaine, a numbing medicine. The spray mixture has a bitter taste. Cetacaine may be sprayed in the mouth for additional numbing. The throat will feel numb for about 30-45 minutes. Possible side effects of the procedure are sneezing, coughing, and minor nasal bleeding. The procedure takes only a few minutes. The patient may feel the endoscope, but it is not painful. Please let Dr. Goldberg know if any discomfort is experienced.

**PLEASE NOTIFY DR. GOLDBERG OR HIS STAFF IF THERE IS AN ALLERGY TO AFRIN, LIDOCAINE OR CETACAINE BEFORE THE NOSE OR MOUTH IS SPRAYED.**

I understand this procedure and its benefits and risks. My questions have been answered and I consent to this procedure.

Signing this consent will allow Dr. Goldberg or his assistants to perform an endoscopy procedure today and in the future. Consent may be revoked at any time.

\_\_\_\_\_  
Signature of patient/guardian

\_\_\_\_\_  
date

\_\_\_\_\_  
Witness

**Jeffrey E. Goldberg, M.D., P.C.**  
**4245 John's Creek Parkway**  
**Suite D**  
**Suwanee, GA 30024**

**RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**I, \_\_\_\_\_, have received Notice of Privacy**

**Practices from Jeffrey E. Goldberg, M.D., P.C.**

\_\_\_\_\_  
**Patient's Name**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Patient/Parent/Guardian**

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[welisten@jgoldbergmd.com](mailto:welisten@jgoldbergmd.com)

Answering all questions as completely as possible will help to avoid any delay at your scheduled visit.

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Appt. date \_\_\_/\_\_\_/\_\_\_

What problems would you like to address at your appointment?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medication Allergies**

\_\_\_\_\_ No known drug allergies

| Allergic to: Drug name | Reaction              | Date                  |
|------------------------|-----------------------|-----------------------|
| _____ / _____ / _____  | _____ / _____ / _____ | _____ / _____ / _____ |
| _____ / _____ / _____  | _____ / _____ / _____ | _____ / _____ / _____ |
| _____ / _____ / _____  | _____ / _____ / _____ | _____ / _____ / _____ |

**Food and Environmental Allergies**

\_\_\_\_\_ No previous allergy testing  
\_\_\_\_\_ Negative allergy testing by Dr. \_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_ Allergic to: FOOD \_\_\_\_\_ Reaction \_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_ Allergic to: Dust, Mold, Pollen \_\_\_\_\_ Reaction \_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_ Allergic to: Other \_\_\_\_\_ Reaction \_\_\_\_\_ Date \_\_\_\_\_

**All Medications Taken Daily or as Needed (prescriptions, over the counter, herbal, vitamins) use additional sheet if needed**

| Name of Drug | Dosage | Taken how often? | Name of Drug | Dosage | Taken how often? |
|--------------|--------|------------------|--------------|--------|------------------|
| _____        | _____  | _____            | _____        | _____  | _____            |
| _____        | _____  | _____            | _____        | _____  | _____            |
| _____        | _____  | _____            | _____        | _____  | _____            |

Has the patient taken any of the following medications in the past 14 days?

Aspirin? YES NO Date and amount of last dose \_\_\_\_\_

Ibuprofen/Advil/Motrin YES NO Date and amount of last dose \_\_\_\_\_

**Pediatric Patients (please circle answer)**

Is your child exposed to tobacco smoke? YES NO  
Is your child in day care/ after school care/ mother's morning out? YES NO  
Is your child's immunizations up to date? YES NO  
Birth History \_\_\_\_\_

**Adult Patients (please circle answer)**

Do you smoke or chew tobacco? YES NO Number of packs per day \_\_\_\_\_  
Alcohol Intake? YES NO How often? \_\_\_\_\_  
Recreational drug use? YES NO How often? \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_ / \_\_\_ / \_\_\_ Appt. date \_\_\_ / \_\_\_ / \_\_\_

Weight \_\_\_\_\_ Height \_\_\_\_\_

Does the patient or any family member have any of the following medical problems or chronic illnesses?

**Patient has complained of: (please circle the symptom)**

**Family Member Has:**

|    |  |              |   |
|----|--|--------------|---|
| NO | Loss of peripheral vision/ double vision/ vision loss<br>Glaucoma  | EYES         | Glaucoma / Other<br>Who:                                  |
| NO | Hearing Loss / Ear Pain/ Vertigo / Ringing in the ear<br>Nasal congestion or obstruction/ Sinusitis/ Allergies<br>Other: | ENT          | Hearing Loss /Ear infections /Allergies<br>Who:           |
| NO | Sore Throat/ Snoring/ Sleep Apnea/ Halitosis<br>Dentures/ Cancer<br>Other:   | Mouth/Throat | Sleep Apnea/ Cancer<br>Who:                               |
| NO | Swelling of hands-feet/ Heart murmur/ Arrythmia<br>Fainting/ Heart Attack/ Angina/ VSD/ ASD/<br>Hypertension             | Heart        | Heart Murmur/ Heart Attack/ VSD/ ASD<br>Arrythmia<br>Who: |

|    |   |                          |  |
|----|---|--------------------------|--|
| NO | Coughing phlegm or blood/ Dry Cough/ Asthma/<br>Wheezing/ Shortness of Breath/ Emphysema/<br>Tuberculosis | Respiratory              | Emphysema/ Asthma/ Tuberculosis/<br>Cancer<br>Who:     |
| NO | Indigestion/ Heartburn/ GERD/ Blood in stool/<br>Diarrhea/ Constipation/ Abdominal Pain                   | Gastrointestinal         | Cancer<br>Who:   |
| NO | Frequent or involuntary urination/ Painful urination/<br>Blood in urine/ Hepatitis                        | Genitourinary &<br>Liver | Liver Cancer/ Bladder Cancer/ Kidney<br>Cancer<br>Who: |
| NO | Unexplained weight loss/ Loss of appetite/<br>Night sweats/ Fever/ Chills                                 | Constitutional           |  |

|    |   |                             |   |
|----|---|-----------------------------|---|
| NO | Headaches/ Loss of coordination/ Seizure/<br>Paralysis/ Stroke/ Numbness or tingling                            | Neurological                | Stroke/ Seizure/ Headaches<br>Who:                  |
| NO | Depression/ Anxiety   | Psychiatric                 | Mental Illness<br>Who:                              |
| NO | Heat-cold intolerance/ Hair loss/ Excessive thirst/<br>Skin texture change/ Diabetes/ Thyroid problem<br>Other: | Endocrine                   | Diabetes/ Thyroid problem/ Cancer<br>Other:<br>Who: |
| NO | Bleed excessively/ Easy bruising/ Anemia/<br>Swollen lymph nodes/ Lymphoma/ Leukemia                            | Hematologic or<br>Lymphatic | Bleeding disorder/ Cancer<br>Who:                   |
| NO | Arthritis/ allergy injections/ HIV/ AIDS  | Allergy/Immune              | Arthritis:<br>Who                                   |

Please list any other serious illnesses or symptoms not mentioned above: \_\_\_\_\_

Please list any surgeries requiring general anesthesia (being put to sleep):

\_\_\_\_\_ Age \_\_\_\_\_  
 \_\_\_\_\_ Age \_\_\_\_\_  
 \_\_\_\_\_ Age \_\_\_\_\_  
 \_\_\_\_\_ Age \_\_\_\_\_

Reviewed and accepted into Patient History:

by \_\_\_\_\_ Date \_\_\_\_\_