SAMUEL C. GOLD, M.D.
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PATIENT REGISTRATION	
NAME:	OCCUPATION:
HOME ADDRESS:	EMPLOYER:
CITY/STATE/ZIP:	EMPLOYER ADDRESS:
HOME PHONE:	CITY/STATE/ZIP:
DATE OF BIRTH:	WORK PHONE:
SOCIAL SECURITY #:	MARITAL STATUS: M S W D
SPOUSAL INFORMATION	
NAME:	
SPOUSE DATE OF BIRTH:	SPOUSE SOCIAL SECURITY #:
EMERGENCY CONTACT PERSON	
NAME:	RELATIONSHIP TO PATIENT:
HOME PHONE:	ALTERNATE PHONE NUMBER:

PLEASE PRESENT YOUR INSURANCE CARDS SO WE MAY COPY THEM FOR OUR RECORDS

PLEASE READ AND SIGN BELOW:

AUTHORIZATION TO PAY INSURANCE BENEFITS: I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE, PRIVATE INSURANCE AND ANY OTHER HEALTH CARE PLANS BE MADE TO ME OR ON MY BEHALF TO SAMUEL C. GOLD, M.D. FOR ANY SERVICES RENDERED TO ME BY DR. GOLD. I AUTHORIZE THE RELEASE OF INFORMATION ABOUT ME TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

GENERAL CONSENT FOR MEDICAL TREATMENT: I HEREBY GIVE SAMUEL C. GOLD, M.D. MY CONSENT FOR ANY NECESSARY MEDICAL EVALUATION AND TREATMENT UPON MYSELF.

_____ _____
PATIENT OR GUARDIAN SIGNATURE DATE

SAMUEL C. GOLD, M.D.
MEDICAL HISTORY

PLEASE TELL US THE NAME OF THE REFERRING DR: _____

1. HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS:
PLEASE FILL IN YES OR NO. IF YES, INDICATE DATE(S) AND TYPE OF TREATMENT.

A. DIABETES MELLITUS	_____	_____
B. HEART ATTACK	_____	_____
HEART DISEASE	_____	_____
ANGINA OR CHEST PAIN	_____	_____
IRREGULAR HEART BEAT	_____	_____
CARDIAC PACEMAKER	_____	_____
C. HIGH BLOOD PRESSURE	_____	_____
D. ANEMIA	_____	_____
E. ASTHMA	_____	_____
EMPHYSEMA	_____	_____
BRONCHITIS	_____	_____
PNEUMONIA	_____	_____
TUBERCULOSIS	_____	_____
F. LIVER DISEASE / JAUNDICE	_____	_____
ULCER	_____	_____
KIDNEY STONES	_____	_____
G. ARTHRITIS	_____	_____
H. CANCER OR TUMOR	_____	_____
I. THYROID DISEASE	_____	_____
J. SEIZURES	_____	_____
K. VARICOSE VEINS	_____	_____
L. OTHER	_____	_____

2. ARE YOU ALLERGIC TO ANY MEDICATIONS OR FOODS?

_____

3. PLEASE LIST ALL EYE MEDICATIONS WITH DOSAGE THAT YOU ARE PRESENTLY USING.

A. _____ B. _____ C. _____

D. _____ E. _____ F. _____

4. PLEASE LIST ALL OTHER MEDICATIONS WITH THE DOSAGE THAT YOU ARE PRESENTLY TAKING.

A. _____ B. _____ C. _____

D. _____ E. _____ F. _____

5. PLEASE INDICATE ANY PREVIOUS EYE SURGERY.

_____

6. PLEASE INDICATE ANY OTHER SURGERIES.

_____

7. ARE YOU A SMOKER? _____ IF SO, HOW MANY PER DAY? _____IN THE PAST? _____

8. PLEASE INDICATE IF YOU HAVE GAINED OR LOST MORE THAN 10 POUNDS IN THE PAST YEAR. PLEASE EXPLAIN THE CIRCUMSTANCES. _____

9. AMONG YOUR BLOOD RELATIVES IS THERE A HISTORY OF THE FOLLOWING?

GLAUCOMA	_____	_____
CATARACTS	_____	_____
LAZY EYE/MUSCLE IMBALANCE	_____	_____
RETINAL DISEASE	_____	_____
MACULAR DISEASE	_____	_____
NIGHT BLINDNESS	_____	_____
COLOR BLINDNESS	_____	_____
UNEXPLAINED VISION LOSS	_____	_____
DIABETES MELLITUS	_____	_____
TUMOR OR CANCER	_____	_____
HIGH BLOOD PRESSURE	_____	_____
HEART DISEASE	_____	_____
BLEEDING DISORDER	_____	_____

10. IF APPLICABLE, ARE YOU PREGNANT? _____

11. PLEASE GIVE THE FOLLOWING INFORMATION ABOUT YOUR MEDICAL PHYSICIAN

NAME _____

ADDRESS _____

PHONE _____