

## **Directions to ROCKVILLE office**

Paul M. Goldberg, D.O., P.C.  
Allergy, Asthma and Clinical Immunology  
Montrose West  
1201 Seven Locks Road  
Rockville, Maryland 20854  
Tele. 301 770-1733---Fax. 301-670-8339

### **Directions**

From 270, take Exit 4 West

Turn Right at 1st light (Seven Locks Road)

Turn Right in .5 miles at 1201 Seven Locks Road. Entrance is on the back corner of the building as you turn right

## **About your appointment**

Please complete the new patient form and bring it with you to your appointment along with your insurance card and appropriate referral if one is required with your insurance.

If the appointment is for a child, please bring only the child being seen. If you must bring a child along who is not the patient, please bring someone who can stay in the waiting area while you are with the doctor.

Copay is due at the time of services. Please bring copay in the form of check, money order or cash.

Dr. Goldberg does not double book, therefore promptness is appreciated. (He tries to begin each patient at the scheduled time)  
Our office policy requires 24 hours notice if you must cancel your appointment.

Thank you

**Patient Name** \_\_\_\_\_

**Day of Appt.** \_\_\_\_\_

**Date of Appt.** \_\_\_\_\_

**Time of Apt**

**Office Location :** **Montrose West**  
**1201 Seven Locks Road**  
**Rockville, MD 20852**  
**301 770-1770**

Paul M. Goldberg, D.O. P.C.  
Allergy, Asthma and Clinical Immunology  
REGISTRATION FORM

Date \_\_\_\_\_ Referred or learned of us by \_\_\_\_\_  
Patient:  
Last Name \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone# HOME \_\_\_\_\_ WORK \_\_\_\_\_ ext \_\_\_\_\_ CELL \_\_\_\_\_  
e-mail address \_\_\_\_\_ Social Security # \_\_\_\_\_  
Employer \_\_\_\_\_ Full Time or Part Time \_\_\_\_\_  
Employer's address \_\_\_\_\_  
Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ (required on insurance claims) Marital Status \_\_\_\_\_ Sex \_\_\_M\_\_\_F  
Student Status: Full Time \_\_\_\_\_ Part Time \_\_\_\_\_ N/A \_\_\_\_\_  
Please list one designated representative who we may contact concerning your issues. \_\_\_\_\_ initial here  
Name \_\_\_\_\_ Phone# \_\_\_\_\_ Relationship \_\_\_\_\_  
Please list an emergency contact person who **does not** live with you.  
Name \_\_\_\_\_ phone # home \_\_\_\_\_ work \_\_\_\_\_  
Please list an emergency Name \_\_\_\_\_ & Number \_\_\_\_\_ of a relative  
**Not living with you**

**INSURANCE INFORMATION Date of Birth of Insured if not the patient \_\_\_\_\_**

Do you have medical insurance? Yes \_\_\_ No \_\_\_ If no, payment is due at time of service \_\_\_\_\_  
If patient is not the insured, whose name is insurance under \_\_\_\_\_  
Relationship to patient: (Spouse, parent, etc) \_\_\_\_\_  
Name of Insured: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_  
Street address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
Place of employment (company name ) \_\_\_\_\_ SS# \_\_\_\_\_  
Address of employer \_\_\_\_\_  
Name of Insurance Company \_\_\_\_\_  
Claims mailing address of insurance company \_\_\_\_\_

Claims phone # for providers to contact insurance \_\_\_\_\_  
Subscriber ID # \_\_\_\_\_ Group # \_\_\_\_\_ Contract # \_\_\_\_\_

**LIST SECONDARY INSURANCE BELOW ( IF APPLICABLE)**

Name of secondary insurance company \_\_\_\_\_  
Claims mailing address of the secondary insurance \_\_\_\_\_  
Claims phone # for providers to contact insurance \_\_\_\_\_  
Subscriber ID# \_\_\_\_\_ group # \_\_\_\_\_ Contract # \_\_\_\_\_

**ASSIGNMENT OF INSURANCE BENEFITS**

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and / or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims or benefits, for services rendered, without obtaining my signature on each and every claim to be submitted for myself and / or dependents, and that I will be bound by the signature as though the undersigned has personally signed the particular claim. I hereby authorize my insurance company to pay and hereby assign directly to Dr. Paul M. Goldberg all benefits, if any, otherwise payable to me for his services as described on the claim forms. I understand I am financially responsible for all charges incurred. I will be responsible for all expenses necessary to collect any remaining balances overdue. I further acknowledge that any insurance benefits, when received by and paid to Dr. Paul M. Goldberg will be credited to my account, in accordance with the above said assignment.

\_\_\_\_\_  
signature date printed name

**Paul M. Goldberg, D.O. P.C.**

Allergy, Asthma and Clinical Immunology

**New Patient Form**

(Please answer pages 1-5 and sign page 6)

Date \_\_\_\_\_ Name \_\_\_\_\_ AGE \_\_\_\_\_

Pharmacy : phone # \_\_\_\_\_ Name and Location \_\_\_\_\_

If referred, by whom \_\_\_\_\_ Who is your primary physician? \_\_\_\_\_

Please list your main problem(s) for coming here in order of severity, **#1 being the most severe**

- itchy eyes      cough
- sneezing      chest tightness
- runny nose      wheezing
- stuffy nose      itching of skin
- postnasal drip      food allergy
- ear popping      insect allergy
- headache      drug allergy
- other \_\_\_\_\_

**DO NOT WRITE ON THIS SIDE**

Please circle the best response ( **N=Never, S=Sometimes, A= really bothers me** )

**EYES**

Do you frequently have:

- A) Itchy eyes    N   S   A
- B) Excessive tearing, watery eyes            N   S   A
- C) Red eyes    N   S   A
- D) A gritty sensation in your eyes            N   S   A
- E) Mucus in the inner corner of the eyes    N   S   A
- F) Puffiness below the eyes, lower lids      N   S   A

**NOSE**

Do you frequently have:

- A) A congested nose                                N   S   A
- B) A watery nose                                    N   S   A
- C1 A lot of post-nasal drip                      N   S   A
- C2 A discolored post-nasal drip                N   S   A  
    (Green, Yellow, or Brown)
- D) The need to clear your throat                N   S   A
- E) An itchy sensation in your nose            N   S   A
- F) An itchy throat or upper palate            N   S   A
- G) An itchy sensation deep in your ears      N   S   A
- H) 3 or more sneezes in a row                N   S   A
- I) A loss of sense of smell or taste            N   S   A
- J) A cough that lasts a month or more        N   S   A
- K) A history of nasal polyps                    N   S   A
- L) Sinus pain, pressure, or recurrent        N   S   A  
    sinus infections
- M) Nasal symptoms coming on like attacks N   S   A

Patient's name \_\_\_\_\_

THROAT

Do you frequently have/feel:

- A) Sore throat N S A
- B) Worse in the morning N S A
- C) Trouble swallowing N S A

EARS

Do you have:

- A) Frequent earaches N S A
- B) Decreased hearing N S A
- C) Ears that pop N S A
- D) Recurrent ear infections N S A

LUNGS

Do you frequently suffer from:

- A) Attacks of wheezing N S A
- B) Episodes of shortness of breath N S A
- C) Increased production of phlegm N S A
- D) Prolonged bouts of coughing, N S A  
Especially after exercise or laughing
- E) Tightness in the chest N S A
- F) Sharp pains with each breath N S A
- G) Has a diagnosis of asthma ever been made? Y N
- H) Have you ever been hospitalized for asthma? Y N
- I) Have you used any steroids or cortisone drugs? Y N  
If so, please specify \_\_\_\_\_
- J) Do you get burning in your stomach? Y N  
If so, when? \_\_\_\_\_

**DO NOT WRITE ON THIS SIDE**

Please check the appropriate space if you experience Wheezing/Coughing . ( **Y=Yes, N=No** )

	Y	N		Y	N
daily	—	—	worse in winter	—	—
weekly	—	—	limits activity	—	—
monthly	—	—	daily medication	—	—
few times / year	—	—	only with colds	—	—
certain exposures	—	—	worse at school/work	—	—
certain seasons	—	—	worse in warm weather	—	—
worse at night	—	—	frequent emergency room visits	—	—
with exercise	—	—	hospitalization	—	—
inhalers help	—	—			

Patient's name \_\_\_\_\_

SKIN

Y N

DO NOT WRITE ON THIS SIDE

Do you have:

- A) Skin that itches intensely
- B) Patches or blotches which appear and disappear abruptly
- C) A history of eczema as a child
- D) A history of hives
- E) A history of swelling around your eyes, lips, or tongue which made it hard to breathe
- F) A rash which occurs with certain clothes
- G) A rash which occurs with certain foods

Please check the appropriate space if you experience Hives/Welts. **(Y=Yes, N=No)**

	Y	N		Y	N
few times per day	<input type="checkbox"/>	<input type="checkbox"/>	worse with anxiety	<input type="checkbox"/>	<input type="checkbox"/>
few times per week	<input type="checkbox"/>	<input type="checkbox"/>	worse with exercise	<input type="checkbox"/>	<input type="checkbox"/>
few times per month	<input type="checkbox"/>	<input type="checkbox"/>	itchy	<input type="checkbox"/>	<input type="checkbox"/>
few times per year	<input type="checkbox"/>	<input type="checkbox"/>	mainly face	<input type="checkbox"/>	<input type="checkbox"/>
all over body	<input type="checkbox"/>	<input type="checkbox"/>	worse with cold	<input type="checkbox"/>	<input type="checkbox"/>
raised large	<input type="checkbox"/>	<input type="checkbox"/>	swelling of body parts	<input type="checkbox"/>	<input type="checkbox"/>
worse with heat	<input type="checkbox"/>	<input type="checkbox"/>	fevers	<input type="checkbox"/>	<input type="checkbox"/>
joint pain	<input type="checkbox"/>	<input type="checkbox"/>	worse with certain foods	<input type="checkbox"/>	<input type="checkbox"/>
stomach aches	<input type="checkbox"/>	<input type="checkbox"/>	medications help	<input type="checkbox"/>	<input type="checkbox"/>
areas of rubbing	<input type="checkbox"/>	<input type="checkbox"/>	other blood studies done	<input type="checkbox"/>	<input type="checkbox"/>

FOOD ALLERGIES

Do you have the following:

- A) A food allergy (specify food) \_\_\_\_\_ Y N
- B) Specify symptoms produced by these foods \_\_\_\_\_  
\_\_\_\_\_
- C) Symptoms occurring within 1-2 hours of eating the food

INSECTS

Do you have allergic reactions to: (circle which apply)

- A) Bees, wasps, hornets, yellow jackets or fire ants. Y N
- B) Other insect bite / or unsure(specify) \_\_\_\_\_
- How long has this been a problem? \_\_\_\_\_

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Patient's name \_\_\_\_\_

When are the symptoms worse? (Check the space)

DO NOT WRITE ON THIS SIDE

Spring \_\_\_ Summer \_\_\_ Fall \_\_\_ Winter \_\_\_  
 Morning \_\_\_ Day \_\_\_ Evening \_\_\_ Sleeping \_\_\_  
 Outdoors \_\_\_ In house \_\_\_ Damp \_\_\_ Windy \_\_\_  
 Dry \_\_\_ Hot \_\_\_ Cold \_\_\_ Exercising \_\_\_  
 Emotionally upset \_\_\_ Eating \_\_\_ School \_\_\_  
 Work \_\_\_ Car \_\_\_ In Grass \_\_\_ In Basement \_\_\_  
 Change of Seasons \_\_\_ Smoke \_\_\_ Around Pets \_\_\_  
 Outdoors \_\_\_ Strong Odors \_\_\_ Moldy, damp rooms \_\_\_  
 Anything else that makes you worse \_\_\_\_\_

What has helped? \_\_\_\_\_  
 Have you had allergy testing? \_\_\_\_\_ Did you have positive results? \_\_\_\_\_  
 Where and when were you tested? \_\_\_\_\_  
 Have you been on allergy shots? \_\_\_\_\_ For how long? \_\_\_\_\_

Days of school or work missed in the past year \_\_\_\_\_

PAST MEDICAL HISTORY

Please list any other medical problems \_\_\_\_\_  
\_\_\_\_\_

Please list hospitalizations (why and when ) \_\_\_\_\_  
\_\_\_\_\_

Have you had any emotional problems? \_\_\_\_\_  
 Please list all current medications \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list any medication allergies known or suspected \_\_\_\_\_  
\_\_\_\_\_

Please list all surgeries \_\_\_\_\_  
\_\_\_\_\_

FAMILY HISTORY:

	Allergies	Asthma	Frequent Coughing	Frequent Infections	Other
Mother	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____
Sister	_____	_____	_____	_____	_____
Brother	_____	_____	_____	_____	_____
Children	_____	_____	_____	_____	_____

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Patient's name \_\_\_\_\_

ENVIRONMENTAL HISTORY:

*Do not write on this side*

Does your home contain:

	Y	N		Y	N		Y	N
Cat	-	-	Central A/C	-	-	Townhouse, house	-	-
Dog	-	-	Gas Heat	-	-	Apartment, condo	-	-
Birds	-	-	Electric Heat	-	-	Stuffed animals	-	-
Other pets	-	-	Oil Heat	-	-	Old mattress	-	-
Plants	-	-	Wood stove	-	-	Feather pillows	-	-
Wall to wall rugs	-	-	Kerosene Heat	-	-	Down comforter	-	-
Hardwood Floors	-	-	Air cleaner	-	-	Damp basement	-	-
Do you smoke?	-	-	Humidifier	-	-	Frequent exposure	-	-
If so, how much and how long? _____						To fumes	-	-

SOCIAL HISTORY:

Occupation: \_\_\_\_\_

Please list any hobbies \_\_\_\_\_

Who does the patient live with? \_\_\_\_\_

Alcohol use? \_\_\_\_\_ How much? \_\_\_\_\_

DO YOU HAVE THE FOLLOWING PROBLEMS?

	Y	N		Y	N
Eye problems	-	-	Bladder/Kidney problems	-	-
Headaches	-	-	Skin problems	-	-
Ear infections	-	-	Joint swelling/Arthritis	-	-
Sore throat	-	-	Hormone problems	-	-
Lung problems	-	-	Nerve / psychiatric problems	-	-
Heart problems	-	-	Diabetes/ Thyroid	-	-
High blood pressure	-	-	Fever	-	-
Stomach problems	-	-	Weight loss	-	-
Diarrhea	-	-	Blood Problems	-	-
Hepatitis	-	-			

Name of the person filling out this history form (if not the patient and relationship)

\_\_\_\_\_

Please feel comfortable to use as much space as you need to help us understand your problems and most pressing concerns.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Thank you very much!!



page 6

Patient's name \_\_\_\_\_

**Please read this page and sign it , thank you.**

It is your responsibility to know your insurance policy and provisions.  
If your insurance requires a referral from a primary care physician, please verify that your referral is valid for the date of your visit.

If you are required to have a referral, and chose to come to our office without a referral you are coming in as a private pay patient and will be billed accordingly.

Many insurance plans have annual deductibles or percentages that the patient is responsible for above and beyond the office visit co pay.  
You will be billed accordingly.

**I have read the above and know that I am responsible for following my insurance company policies and I am financially responsible for all charges incurred.**

\_\_\_\_\_  
Printed name of the insured

\_\_\_\_\_  
Signature of Insured  
or Responsible Party

Credit Card Payment  
Paul M. Goldberg, D.O.  
1225 Martha Custis Drive, C-7  
Alexandria, VA 22302  
Virginia 703-998-5676 or Maryland 301-670-8338  
Fax to: 301-670-8339, or mail to above address.  
The information may also be called to the above phone numbers.

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Today's date \_\_\_\_\_  
Type of credit card \_\_\_\_\_ Visa, \_\_\_\_\_ Master, \_\_\_\_\_ AmEx, \_\_\_\_\_ Discover

Credit Card Number \_\_\_\_\_  
Expiration Date \_\_\_\_\_

Name of Patient the payment is being applied to \_\_\_\_\_

Name as it appears on Credit Card \_\_\_\_\_

Address where Credit card bills are sent:

Street address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # if we need to contact you about this transaction \_\_\_\_\_

Total amount you are paying to Dr. Goldberg on this transaction \$ \_\_\_\_\_

Please print the above amount \_\_\_\_\_

\_\_\_\_\_  
Signature of cardholder

Paul M. Goldberg, D.O., P.C.

## Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you get access to this information. PLEASE REVIEW IT CAREFULLY

### **I. We have a legal duty to safeguard your Protected Health Information (PHI)**

We are required to protect the privacy of your health information. This (PHI) includes what can be used to identify you that we've created or received about your past, present or future health or condition, the provision of health care to you, or payment for this health care. We must provide you with this notice about our privacy practice that explains how, when and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are required to follow the privacy practices that are described in this section.

However, we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post a new notice on our website, or in the office.

### **II. How we may use and disclose your protected health information.**

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your specific authorization. Below we describe different categories of our uses and discloses.

#### **A. We may use or disclose your PHI for the following reasons: treatment, payment and healthcare operations.**

1. **For treatment.** We may disclose your PHI to physicians, PAs, nurses and other health care personnel who provide you with health care services or are involved in your care.
2. **To obtain payment for treatment.** We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you.
3. **For health care operations.** We may disclose your PHI in order to operate this facility.

#### **B. Certain uses and disclosures do not require your authorization. We may use and disclose your PHI without your authorization for the following reasons:**

1. When required by federal, state or local law, judicial or administrative proceedings, or law enforcement.
2. For public health activities
3. For health oversight activities
4. For research purposes
5. To avoid harm
6. For specific government functions
7. For workers' compensation purposes
8. Appointment reminder and health related benefits or services
9. For purpose of organ donation

- C. **Use and disclosures require you to have the opportunity to object.** We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part in writing to our officer. The opportunity to consent may be obtained retroactively in emergency situation. If you allow another person to schedule your appointments, or make payments on your behalf, we will take it that those persons are allowed access to your PHI. (for example: a spouse or significant other, or parent of college student scheduling appointments, or paying bills are people we will also relate your PHI)
- D. **All other use and disclosures require your prior written authorization.** In any other situation not described in Sections II A, B, and C above, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing, to stop any future uses and disclosures (to the extent that we haven't taken any action relying on the authorization).

### III. **WHAT RIGHTS YOU HAVE REGARDING YOUR PHI**

You have the following rights with respect to your PHI:

- A. The right to request restrictions on certain uses and disclosures of protected health information.
- B. The right to reasonable requests to receive confidential communications of protected health information from us by alternative means so long as we can easily provide it in the format you request.
- C. The right to inspect and see copies of your protected health information, but you must make the request in writing.
- D. The right to get a list of certain disclosures we have made.
- E. The right to correct or update your protected health information
- F. The right to obtain a paper copy of this notice from us upon request.

### IV. **PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.**

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of Department of Health and Human Services, please contact: Office Manager, Paul M Goldberg, DO, 6282 Montrose Road, Rockville, MD 20852, phone 301-670-8338.

If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the Office Manager above. You may also send a written complaint to the Secretary of the Department of Health and Human Services:

Office of Civil Rights  
200 Independence Avenue, S.W.  
Washington, DC 20201  
1-800-368-1019  
[www.hhs.gov/ocr/hipaa](http://www.hhs.gov/ocr/hipaa)

Paul M. Goldberg, D.O., P.C.

I have reviewed a copy of the Notice of Privacy Practices of Paul M. Goldberg, D.O., P.C. and understand that I will be contacted by phone, email, text, mail or ans. machine, or message with one of the people below.

Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

Listed below are the people who can have access to my PHI:

Spouse –Printed Name \_\_\_\_\_

Phone # to reach above person \_\_\_\_\_

Partner-Printed Name \_\_\_\_\_

Phone # to reach above person \_\_\_\_\_

Parents Printed names \_\_\_\_\_ and phone # \_\_\_\_\_

\_\_\_\_\_  
Phone # \_\_\_\_\_

Children (18 or older) names and phone #s

\_\_\_\_\_

\_\_\_\_\_

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Other, including relationship and phone \_\_\_\_\_