Pain Management Physicians Of South Florida, PL
Andrew J. Goldberg, M.D.

TODAY'S DATE _____/_____/_____

PERSONAL INFORMATION

First Name: _____ Last Name: _____ SS#: _____

Permanent Address: _____ City: _____ St: ____ Zip: _____

Phone: _____ Sex: _____ Date of Birth: _____ Age: _____

Marital Status _____ Emergency Contact: _____ Phone: _____

Employer: _____ Phone: _____

Your Drug Store: _____ Phone: _____ City: _____

INSURANCE INFORMATION

All patients, we ask that you provide us with your id and insurance cards, both primary and secondary. We will photocopy them for our files. All patients with a per visit co-pay amount, co-pay will be collected at time of visit. Please be prepared to pay per visit co-pay.

Primary Insurance Company: _____ Phone: _____

Is this: ☐ Medicare ☐ Medicare HMO ☐ PPO ☐ HMO ☐ Other
Contract #: _____ Group #: _____ Subscriber #: _____

Name of Policy Holder: _____ SS#: _____ DOB: _____

Relationship to Patient: _____ Co-pay Amount: _____

Secondary Insurance: _____ Subscriber: _____ Contract # _____

Do you need a referral from your regular doctor to see a specialist: ☐yes ☐no

Referring Doctors' Name	Phone Number	Address:

Primary Care Physicians' Name	Phone Number	Address:

HIPPA QUESTIONS

As my doctor, you or your staff may:
A☐Call my home/cell phone and if necessary leave a message on the answering machine / voice mail/ with family member for me to call you back to schedule or to return your call.
B☐ Call my workplace and if necessary leave a message for me to call you back to schedule an appointment or just return your call.
Note: You will be billed separately for services provided by your surgeon, anesthesiologist or pathologist.

Patient's Name	Patient's or Guardian's Signature	Date

Mailing address: 5944 Coral ridge dr #190 *coral springs, fl 33076
Office address: 8880 Royal Palm Blvd. #103 Coral Springs, Fl 33065
954-975-8233 phone * 954-974-2335 fax * pmpsf@bellsouth.net