Mytien T. Goldberg, MD
Board Certified Plastic & Reconstructive Surgery
Hand & Microsurgery
23560 Madison Street, Suite 103
Torrance, CA 90505

Personal Information:

Patient Name ______________________________ DOB _______________ Date _____________________

Address ____ Apt# _____________________

City ______________________________________ State _______________ Zip _____________________

Home Phone (____) _________________ Cell Phone (____) ______________________

Work Phone (____) _________________ Preferred Contact #: Home ❘ Cell ❘ Work ❘

Email Address ____

Occupation _________________________ Employer _______________________________

Sex: Male ❘ Female ❘ Marital Status: S ❘ M ❘ W ❘ D ❘

Emergency Contact Name/Phone Number: ________________________/(____)_________

How did you hear about us? Please be specific:

Website ______________ Web Search ______ Walk-In ______

Patient Referral (Please provide name) ____

Physician Referral(Please provide name) ____

The web is becoming a key way patients learn about our practice. Do you participate in any of the following (circle all that apply):

Yelp

Facebook

Twitter

Angie's List

RealSelf

Blogging If yes, where can we see it? http://_________________________

2) What website(s) did you find helpful to use in researching our practice or the procedure?

____

Please give a brief description of your injury or reason to be seen by Dr. Goldberg:

____

____

Are you Right or Left handed?____________What was the date of your injury or onset of symptoms?_________

How long have you thought about plastic surgery?__________________________

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Age _________ Current Weight __________ lbs Height ____________

Date of last physical __________ Name of Family Physician _________________________________

Is your general health good? Yes ☐ No ☐

List all medications you are taking (prescription and OTC):

____

____

Do you take Aspirin, Advil, Motrin, Ibuprofen, or anti-inflammatory medication more than once per week?

Yes ☐ No ☐ If yes, please explain:

____

____

Do you smoke? Yes ☐ No ☐ If yes, how many per day/for how many years: _______________________________

Do you drink alcohol? Yes ☐ No ☐ If yes, how much/how often: ____

Present/Past Medical History:

Have you ever had any of the following (please circle):

Asthma	Arthritis	Anemia
Autoimmune disorder	Blood disorder	Chest Pain
Chronic diarrhea	Clotting disorder	Colon problems
Diabetes	Depression	Easily Bruise
Excessive scarring	Excessive bleeding	Heart Attack
Heart valve disease	Heart valve replacement	Heart Failure
High blood pressure	Hepatitis	HIV
Irregular heart beat	Intestinal problems	Keloids
Kidney disease	Liver disease	Lung disease
Multiple Schlerosis	Muscular Dystrophy	MVP
Migraines	Rheumatic fever	Shortness of breath
Seizures	Stroke	Stomach problems
Thyroid disorder		

Cancer: Please list type ____

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List all surgeries or hospitalizations with dates:

____

____

____

Have you ever had any cosmetic procedures in the past? Please list with dates:

____

____

____

To the best of my knowledge, the information provided above is true and accurate.

Patient Signature ________________________________ Date ___________________

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PATIENT'S INSURANCE INFORMATION

Please provide your insurance information or the information of the financially responsible party (if other than patient) : Wife Husband Parent Other

Patient's Name ____________ DOB ______

Employer ____________

Address ____________

City ____________ Zip ______

Work phone (____________) ______ Ext ______

Health Insurance policy ____________

Policy Number ____________

Policy Holder's Name ____________

Expiration Date ____________

Patient's Occupation ____________

Patient's Social Security # ____________

Spouse Name ____________ DOB ______

Employer ____________

Address ____________

City ____________ Zip ______

Work Phone (______) ____________ Ext ______

Health insurance policy ____________

Policy Number ____________

Policy Holder's Name ____________

Expiration Date ____________

Occupation ____________

Social Security # ____________

Authorization of Health Information Release

I hereby authorize Dr. Mytien T. Goldberg to release any and all medical information to the above named insurance carrier for purposes of claims administration and evaluation, utilization review and audit. This authorization remains valid and effective from the date of signing until revoked in writing. I understand that I may request a copy of this authorization. I have read this authorization and I understand it fully.

I authorize payment benefits to Dr. Mytien Goldberg as agreed upon at the time of treatment for services rendered. I understand I am liable for any deductibles, copays or non-covered services. I also verify I have provided Dr. Mytien Goldberg with my correct insurance information. If it is incorrect, I will be responsible for the full monetary amount of all my services. This authorization shall be valid unless rescinded by one at a later date.

Signature ____________________ Date: ____________

If the patient is a minor (under 18 years of age) or is otherwise unable to sign on their own behalf, the patient representative who completed these forms should complete the following information:

Patient's Representative Name ____________ Signature ____________

Relationship to patient: ____________