Lauren T. Goldstein, MD

Diplomate American Board of Psychiatry and Neurology
General Psychiatry - Sexual Disorders

495 Iron Bridge Road – Suite 11
Freehold, New Jersey 07728
(732) 683-1283
FAX (732) 683-1619

CONFIDENTAL Registration Information

Patient Information	Name (Last, First, MI)		Today's Date Age as of this Date	
Street Address *(if PO Box also give physical home address)* APT. #____		Marital Status □ Single □ Married □ Divorced □ Widowed □ Separated		
City	State	Zip	Gender □ Male □ Female	Date of Birth
Social Security #	Daytime Phone ( )	Evening Phone ( )	Cell Phone ( )	
Occupation:	Employer Name and Address:		If Student: □ Full time □ Part Time	

Spouse's information or Parent's information	**Emergency Contact**	**Referral Info** How did you hear about us?
Spouse's or Parents Name:	In case of an emergency, we may contact: Name___________________________________ Daytime Phone ( ) ___________________ Evening Phone ( ) ___________________ Relationship to Patient ____________________	□ From a Current/Prior Patient Name____________________ □ Internet □ Goggle search □ Other Web avenue _____________________________ □ Newspaper Which one? ______________________________ □ From a physician Name_________________ Town_______ □ Yellow pages □ Referred by health plan/insurance directory
Spouse's or Parents Employer:	*Your Primary Care Physician is:* *NAME*_________________________________ *Town*__________________________________	

Insurance Information		
Name of Primary Insurance Company	Policy #	Group #
Please indicate the policyholder for the primary insurance: □Self □Spouse □Parent □Other __________		

TURN

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION and ACKNOWLEDGMENT of RECEIPT OF NOTICE OF PRIVACY PRACTICES and FINANCIAL/ CANCELLATION POLICY	***Please read the following and sign below:***

Assignment of Benefits and Release of Information: By signing below, I hereby assign all insurance benefits to which I am entitled including Medicare and/or any other insurance or health plans to Lauren T. Goldstein, MD. I authorize Dr. Goldstein release to the Health Care Financing Administration, its agents or to other insurance company any information that is in the record and is necessary to secure payment.

Notice of Privacy Practices Acknowledgment By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices.

Financial and Cancellation Policy Acknowledgment I understand that by signing below, I agree to abide to the financial and cancellation policy described herein.
Current fees:

Initial Evaluation $400.00
45 Minutes session $225.00
30 Minutes session $150.00
Medicare Patient fees: Subject to current medicare fee schedule (please ask office staff for fee schedule)

I am financially responsible for all charges. I understand that Dr. Goldstein does not participate in any insurance plans. Payment in full is due *at the time of service*. I may pay by cash, check or credit card (VISA, MC, or AMEX).
The office will give me a statement for me to submit to my insurance company for my reimbursement.

Cancellation policy: I agree to be responsible for the full office visit charge for any appointment that I miss, no-show, or do not cancel within 24 hours. Monday appointments must be canceled by the Friday afternoon preceding the appointment to avoid being responsible for the full office visit charge.
Returned Check Fee $40.00. Medical record copy charge one dollar per page plus postage.
Overdue accounts: Outstanding balances are due upon receipt of statement. An interest charge of 1.5% per month will be added to unpaid patient balances. I understand that if account goes to collections for non-payment I will be responsible for all court and legal fees.

X____ Date:____________
Signature of Patient or responsible Party

TURN for Clinical data:

Are you currently taking any medications: Yes: ____ No: _______ if yes, please list:

Medication: ______________________ Dose: ________________________
Medication: ______________________ Dose: ________________________
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Medication: ______________________ Dose: ________________________

Have any of your relatives had any psychiatric problems? Yes_____ No_____

If yes, state problem, hospitalization history, and medications, if known:

Relation	Type of Problem	Hospitalization	Medications
_____________	_____________	____________	___________
_____________	_____________	____________	___________
_____________	_____________	____________	___________

Have you or any of your close relatives had any of the following:

	I Have	A relative has (if so, whom)
1. Tuberculosis	______	____________
2. Diabetes	______	____________
3. Cancer	______	____________
4. High Blood Pressure	______	____________
5. Heart Disease	______	____________
6. Rheumatic Fever	______	____________
7. Asthma	______	____________
8. Thyroid Disease or Goiter	______	____________
9. Hay Fever	______	____________
10. Bleeding tendency or anemia	______	____________
11. Arthritis or rheumatism	______	____________
12. Gout	______	____________
!3. Seizures/neurological disease	______	____________

Has your general health in the past been good? Yes_____ No: _____ (If no, explain)
____
____

List all medical/ surgical hospital admission:

Hospital	Date	Illness/Operation
_____________________	__________	__________________
_____________________	__________	__________________
____________________	__________	__________________

TURN

Do you have any allergies to medications: Yes____ No____ If yes, please list:

Allergies	Name of Medication(s)	Dose (s)
____________________	______________________	________________
____________________	______________________	________________

Please List other allergies____

Have you ever seen a psychiatrist/ psychotherapist before? Yes_____ No______
If yes, please list:

1. Name of Therapist / Location____
   Telephone __________________ Date of Treatment_______________
   Type of treatment____________________________
   Hospitalization? ____________________________
   Medications________________________________

2. Name of Therapist / Location____
   Telephone __________________ Date of Treatment_______________
   Type of treatment____________________________
   Hospitalization? ____________________________
   Medications________________________________

3. Name of Therapist / Location____
   Telephone __________________ Date of Treatment_______________
   Type of treatment____________________________
   Hospitalization? ____________________________
   Medications________________________________

Current medical problems:
____

Date and place of Last Physical Examination: ____

List any present medical complaints and how long you have suffered from each:

Medical Complaint(s)	Length of Time
____________________________________	_________________________________
____________________________________	_________________________________
____________________________________	_________________________________

State health or cause of death for each of the following (give ages):

	Health or Cause of Death	Age
1. Father	_____________________	_______
2. Mother	_____________________	_______
3. Brother (s)	_____________________	_______
4. Sister (s)	_____________________	_______

Reviewed by M.D. _______________________________________