Murray G. Goldberg, M.D.
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NAME	SEX AT BIRTH M☐ F☐	DATE OF BIRTH	AGE	SOCIAL SECURITY NO.

FLORIDA ADDRESS	CITY AND STATE	ZIP CODE	TIME SPENT AT ADDRESS

NORTHERN ADDRESS	CITY AND STATE	TIME SPENT AT ADDRESS

HOME PHONE NUMBER	CELL PHONE NUMBER	EMAIL ADDRESS

SPOUSE'S/PARTNERS NAME	NUMBER OF CHILDREN AND AGES	MARITAL STATUS S M DP W D

EMERGENCY CONTACT NAME	RELATIONSHIP	PHONE NUMBER	BUSINESS PHONE NO.

PRIMARY CARE PROVIDER	PHONE NUMBER	FAX NUMBER

PHARMACY ADDRESS AND PHONE NUMBER	REFERRED BY

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE	POLICY HOLDER

GOVERNMENT-MANDATED QUESTIONS:

RACE ☐ Caucasian ☐ Afro-American ☐ Hispanic ☐ Asian ☐ American Indian ☐ Alaskan Native ☐ Pacific Islander Other _____
PRIMARY LANGUAGE ☐ English ☐ Spanish ☐ Other _____ ☐ Declined

ETHNICITY (CHECK APPROPRIATE)
☐ NO, Not Hispanic, Latino, or Spanish Origin ☐ YES, Mexican, Mexican-American or Chicano Origin
☐ YES, Puerto Rican Origin ☐ YES, another Hispanic, Latino or Spanish Origin ☐ Declined

DATE:

I certify that all the above information is accurate. I hereby authorize the release of any information necessary to process my claims. I hereby authorize the release of my medical information to my referring healthcare provider as well as to those I may be referred to for consultation and/or treatment. Payment of any government benefits may be made either to me or to the party who claims the assignment.

I authorize the payment of medical benefits directly to my physician. I am financially responsible for any unpaid balance due. I agree to pay any deductibles, co-insurance, and co-pays. I understand that I am financially responsible for any charges not covered by my insurance and if I fail to give updated current information and the claim is denied, I will be responsible for the entire balance.

Missing your appointment or failure to give us 24 hours' notice of canceling an appointment creates an undue burden and increases the cost of care to other patients. Should you miss your appointment, you will be billed a $50.00 missed appointment fee. If you miss 3 appointments, you will be dismissed from the practice.

To be as accurate as possible, we update personal demographics, insurance information, medical history, and medications at each visit. If you have tests as part of your appointment, we promise to get the results to you as quickly as possible. Some tests/labs are performed by outside parties, in such cases they will bill you separately.

We accept cash, check or credit card. We send 3 statements, after which delinquent accounts are turned over to a collection agency. You understand and agree that if we are forced to send your account to collection, a fee of 50% of the unpaid balance will be added. This amount shall be in addition to any other cost incurred directly or indirectly to collect amounts owed under this agreement.

Signed _____ Date _____