



DR. JEFF GOLD, DC, PTA

Work Injuries, Sports Injuries, Auto Injuries, and Family Health

CONFIDENTIAL PATIENT INFORMATION

Name: _____ Social Security: _____ Home phone: _____

Address: _____ City: _____ Zip: _____

Age: _____ Birth date: _____ Marital status: **M S W D** Number of children: _____

Occupation: _____ Employer: _____

Address: _____ Office phone: _____

Spouse's Name: _____ Occupation: _____

Employer: _____

Patient's nearest relative: _____ Phone: _____

Referred by: _____ Purpose of appointment: _____

Is this condition due to: Personal Injury On-the-job-injury Auto Accident Other _____

Date symptoms appeared of accident happened: _____

Have you ever had same or similar condition? Yes No If yes, when and describe please: _____

Have you seen any other doctors for this condition? Yes No Their names: _____

What medications, if any, are you taking? _____

Have you lost any days from work? Yes No The date of you last physical: _____

What operations have you had? _____ Female: Are you pregnant? _____

PLEASE LIST YOUR SYMPTOMS IN ORDER OF SEVERITY:

1. _____
2. _____
3. _____
4. _____
5. _____

PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of person responsible for payment: _____

Are you insured? Yes No Company: _____

Have you met your deductible? Yes No

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that the Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's signature: _____ Date: _____

Guardian or spouse's signature: _____ Date: _____



NAME _____

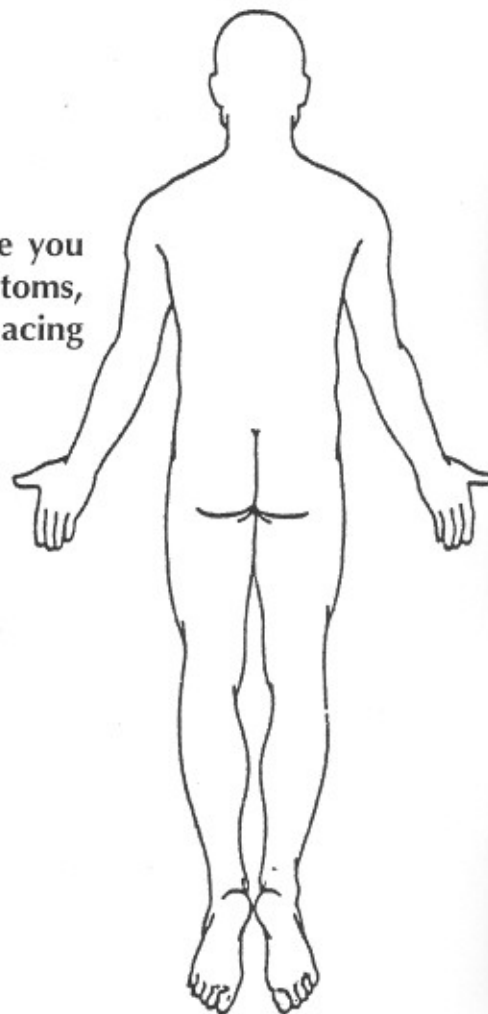
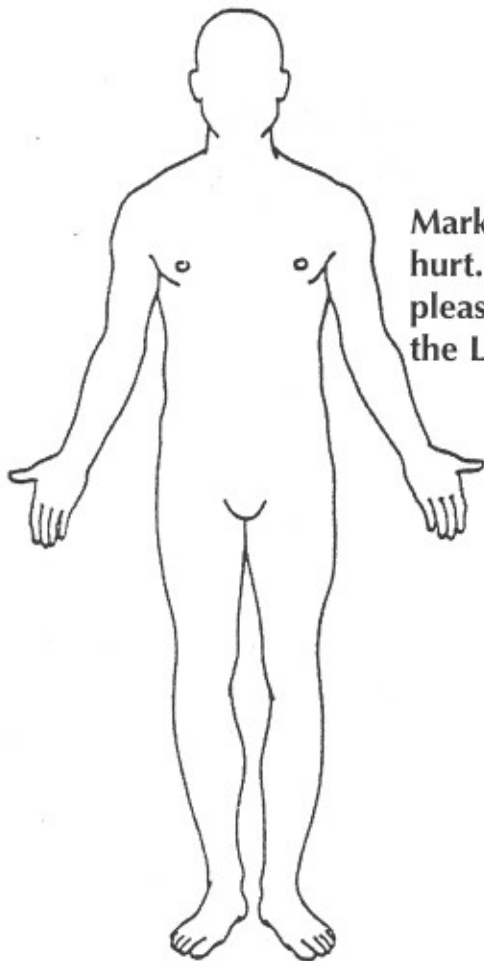
DATE _____

FRONT

Show Me Where It Hurts

BACK

Mark these drawings according to where you hurt. If you feel any of the following symptoms, please indicate where you feel them by placing the LETTER shown here on the diagram..



- | | |
|----------|---|
| ACHING | A |
| BURNING | B |
| NUMBNESS | N |
| STABBING | S |
| TINGLING | T |

FRONT

BACK

PLEASE CIRCLE YOUR LEVEL OF PAIN





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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPTIONS

I, _____ (Name of Individual) consent to Dr Gold's ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of service rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of the Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority