DR. GOLD'S
OPTIMAL LIVING INSTITUTE
Board Certified in Family & Holistic Medicine

2901 W Busch Blvd, Suite 604
Tampa, FL 33618
www.dgoli.com / 813-379-7092

# Intake Form

**Please print neatly and complete accurately, so we can fully serve you.☺**

**Name: _____ Date of Birth: _____ Age:_____**

**Address: _____ Gender : ☐ F / ☐ M / ☐ Other: _____**

**City: _____ State: _____ Zip: _____**

**Cell Phone #: _____ Work #: _____ Home #:_____**

**Preferred method of contact: ☐ Cell ☐ Work ☐ Home**

**E-mail:_____**

**May we leave a confidential Message? ☐ Yes ☐ No**

**Drivers License #: _____ SS#: _____ - _____ - _____**

**Marital Status: ☐ Married ☐ Single ☐ Partnered ☐ Divorced ☐ Widowed ☐ Separated**

**Emergency Contact: _____ Phone: _____ Relationship: _____**

**Who can we thank for having you come here?**
**_____**

**How did you find us?**

**☐ Google ☐ dgoli.com ☐ Other Online: _____**

**What brings you to our office today? Please list all reasons:**
**_____**

**_____**

Patient Name: _____

**Social and Wellness History**

Who do you live with (include all family members, friends, pets, aliens, etc & ages)☺:
_____

_____

What do you do for a living?_____ Employed by (if applicable)_____

Do you enjoy what you do? ☐Yes /☐No Please explain: _____

_____

Spouse/Partner Name (if not above) _____Phone _____

Do you currently or have you ever used any Tobacco Products? ☐Yes ☐No If yes, explain?
_____

Do you currently or have you ever used any alcohol? ☐Yes ☐No If yes, explain?
_____

Do you currently or have you ever used any drugs including marijuana? ☐Yes ☐No If yes, explain?
_____

**Personal Safety**
Do you feel safe at home? ☐ Yes ☐No If no, explain?
_____

List all Activities you do (include when, where, how long, intensity, enjoyment, and if compete) or ☐Not Active

_____

List all healthy items you consume, including beverages (include where, when, amount). If numerous healthy items, include the most common or ☐ I do not consume healthy items

_____

_____

_____

**Sleep**
What time do you go to sleep?

What time do you wake up?

Do feel well rested when you wake up? ☐Yes ☐No If no, explain?

Patient Name: _____

**Medical History**

List all medical conditions with which you have been diagnosed (include date of diagnosis, location, and by whom), or ☐ No medical conditions.

_____

List all allergies (include when and how diagnosed, and reactions) or ☐ No allergies

_____

List all meds & supplements (include frequency, strength, and length of use) or ☐ No meds ☐ No supplements

_____

List all surgeries (Include when, where and by whom) or ☐ No surgeries

_____

List all hospitalizations (Include when, where and why) or ☐ No hospitalizations

_____

List all Family illnesses (include relationship, illness, age/date diagnosed, if died age/date & reason) or ☐ Adopted ☐ No Family illnesses ☐ Unknown

_____

List any concerns with any parts of your body (include area, reason for concern, when began, evaluation & who is managing this) or ☐ No concerns with any body parts

_____

Patient Name: _____

**Accident Information**

Date of Accident:

_____

Insurance Company Name:

_____

Insurance Company Address:

_____

_____

_____

Policy Number:

_____

Claim Number:

_____

Insurance Company Adjuster Name:

_____

Insurance Company Adjuster Phone Number:

_____

## Dr. Gold's Optimal Living Institute (www.dgoli.com) ☺: Pain Form

Name: _____ Date: _____ DOB: _____

### PROBLEM / CONDITION

**1. a.Date Motor vehicle Accident (MVA)**_____

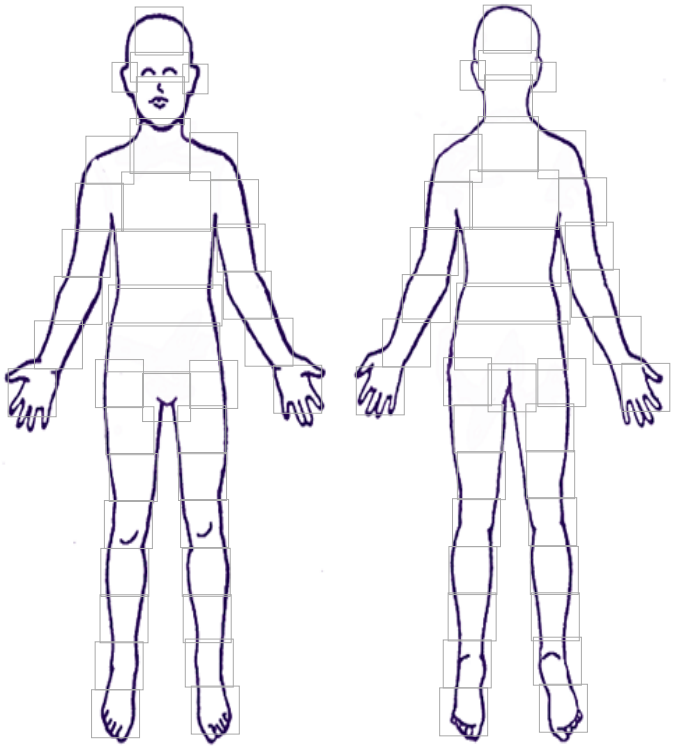
**b.Were you driving?** ☐Yes ☐No

**c.Wearing seat belt?** ☐Yes ☐No

**d.Airbags deployed?** ☐Yes ☐No

e.**Where was car impacted?** ☐back ☐front ☐side

f.List any **NEW** symptoms since the recent motor vehicle accident_____



**2. Where is the problem? (circle/mark on the diagram)**

**3. How often do you experience your symptoms (as a % of the time)?**

☐ Constantly (76-100%) ☐ Occasionally (26-50%)

☐ Frequently (51-75%) ☐ Intermittently (1-25%)

**4. How would you describe the type of pain?**

| | |
|---|---|
| ☐Sharp | ☐Numb |
| ☐Dull | ☐Tingly |
| ☐Diffuse | ☐Sharp with motion |
| ☐Achy | ☐Shooting with motion |
| ☐Burning | ☐Stabbing with motion |
| ☐Shooting | ☐Electric like with motion |
| ☐Stabbing | ☐Other:_____ |

**5. How are your symptoms changing with time?**

☐ Getting Worse ☐ No Change ☐ Getting Better

**6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?**

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

**7. How much has the problem interfered with your work?**

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How: _____

**8. How much has the problem interfered with your social activities?**

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How: _____

**9. Who else have you seen for your problem?**

| | | |
|---|---|---|
| ☐Chiropractor | ☐Neurologist | ☐Other: _____ |
| ☐ER physician | ☐Orthopedist | ☐No one |
| ☐Massage Therapist | ☐Physical Therapist | |

**10. Do you consider this problem to be severe?** ☐ Yes ☐ Yes, at times ☐ No

**11. What helps your problem?**_____

**12. What worsens your problem?**_____

**13. Do you feel you will get better?** ☐ Yes ☐ No. If no why not? _____

**14. What medications are you taking for this condition?**_____

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# HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services - www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

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# HIPAA Information and Consent Form (continued)

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

**I, _____on _____ (date) do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.**

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## CANCELLATION POLICY AND PAYMENT AUTHORIZATION

Our schedule is usually booked several weeks in advance. This makes it difficult for patients to make appointments on short notice. We try to accommodate everyone the best we can.

**CANCELLATION POLICY**

**Please note that if you fail to notify the office of an appointment cancellation 24 hours prior to that appointment, you will be charged a $50 fee for that appointment.** We ask that you leave a credit card number to hold your appointment. In the event that you do not show or cancel an appointment in less than 24 hours from the time of the appointment, we will charge the fee to the card. **Please sign below to let us know that you have read and understand our cancellation policy.**

Accepted and Acknowledged:

| _____ | _____ | _____ |
|---|---|---|
| Print Patient Name | Signature | Date |

I understand the above text and agree to comply.

| _____ | | |
|---|---|---|
| Credit Card Number | Exp. Date | PIN |

| _____ | |
|---|---|
| Name of Card Holder | Type of Card |

Print name of patient

Signature of patient Date

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**INFORMED CONSENT**

In consideration of your undertaking to treatment, I agree to the following:

**CONSENT TO TREAT:** I request and give consent to Tanya Gold, MD, and Dr. Gold's Optimal Living Institute, to provide and perform medical/surgical treatments, tests, procedures, medications and other services and supplies as are considered necessary or beneficial for my health and well-being. I understand that if Tanya Gold, MD, is not my primary care physician that she is only responsible for treating medical conditions associated with my reason for seeking treatment with her. I further acknowledge that if Tanya Gold, MD is my primary care physician, that she only provides select medical services as disclosed in her form Select Primary Care Services and that another provider should perform all other routine medical screening and immunizations not performed by Tanya Gold, MD (e.g. EKGs, PAP smears). I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

INITIAL: _____

**MEDICARE CERTIFICATION:** I acknowledge that Dr. Gold's Optimal Living Institute is a par provider with Medicare, but provides non-covered services, and will not submit any claims to Medicare on my behalf. I further acknowledge that Dr. Gold's Optimal Living Institute has given me the opportunity to discuss financial arrangements and has provided an Advanced Beneficiary Notification (ABN) for services rendered. I will pay Dr. Gold's Optimal Living Institute out of pocket.

INITIAL: _____

**FINANCIAL AGREEMENT:** I understand all accounts are the full responsibility of the patient and/or the patient's responsible party/guarantor. Dr. Gold's Optimal Living Institute will not assist patients in obtaining insurance benefits, but will provide patients with the necessary documentation so that they may submit their own claims to their insurance provider. Dr. Gold's Optimal Living Institute makes no representations about the services provided and whether or not they will be covered by the patient's insurance carrier. I will pay Dr. Gold's Optimal Living Institute out of pocket. In the case of default payment, I promise to pay any legal interest on the balance due, together with collection costs and reasonable attorney fees incurred to effect collection of this account and future outstanding accounts. If I fail to notify the office of a cancellation of an appointment within 24 hours of that appointment, I understand that I will be responsible for the full payment of that appointment

INITIAL: _____

**PATIENTS NAME: _____ DATE: _____**

**PATIENTS SIGNATURE: _____ DATE: _____**

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**AUTHORIZATION TO DISCLOSE MEDICAL RECORDS**

Patient Name:_____

Date of Birth:_____ Social Security Number:_____

Doctor's Name & Address:_____

Phone #:_____ Fax #:_____

I authorize the health information to be disclosed to and used by the following individual organization:

**Dr. Gold's Optimal Living Institute**
2901 W Busch Blvd, Suite 604
Tampa, FL 33618
Telephone 813-379-7092 • Fax 888-479-3526

The type and amount of information to be disclosed is as follows (as applicable):

Last TWO Progress Notes, Complete Vaccination Record, All Laboratory Results, Latest Colonoscopy and EGD with reports, Most recent EKG, Most recent stress test, and Last complete physical. Also include any abnormal EKGs, stress tests, or other abnormal test results.

For women, please include most recent pap smears, mammograms, breast ultrasound, breast MRI, and breast biopsy with diagnosis (if done).

PLEASE DO NOT SEND COMPLETE MEDICAL RECORDS, ONLY SEND WHAT IS REQUESTED.

Other: _____

1. The medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.
2. This authorization will expire without my express revocation, 180 days from the date below.
3. My signature on this authorization form is strictly voluntary.
4. My treatment, payment, enrollment or eligibility for benefits may not be conditional on signing this authorization.
5. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on actions taken prior to receiving the revocation.
6. A copy of this authorization or my signature thereon, may be utilized with the same effectiveness as an original.

_____ _____
Signature of Patient or Authorized Personal Representative Date

_____ _____
Printed Name of Patient or Authorized Personal Representative Relationship to Patient

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Date: _____

I, _____, patient of _____,
(Printed Name) (Doctor's Name)
am being referred to Dr. Tanya Gold, M.D. for an examination due to an accident

which occurred on _____. I understand that Dr. Gold is not my
(Date)
primary care physician, and all medical inquiries should be directed to

_____.
(Primary Care Physician's Name)

_____ _____
Patient Name – Printed Patient Signature

_____
Provider Signature