Gregory E. Gould, D.O., P.C.
60005 Campground Road, Suite 600, Washington, MI 48094

## Patient Demographics and Consent to Treatment

Patient's First Name ________________________ M.I. ____ Last Name _______________________

Address _______________________________ City _________________State ______ Zip ________

Home Phone ____________________ Cell ____________________ Work __________________

Can we leave a message at your home or on your cell phone? ◯ Yes ◯ No

Date of Birth _______________ ◯ Male ◯ Female SS# _________________________

Employer ______________________________ Employer Phone ______________________

Marital Status ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Spouse Name ________________________________ Date of Birth ____________________

Employer ______________________________ Employer Phone ______________________

Can we contact you at your work? Only if needed? ◯ Yes ◯ No

**Emergency Contact** (Someone not living in your home with you)

Name _________________________________________ Phone ______________________

Relationship to Patient? _________________________________

**Parent or Guardian** (Complete this portion if the patient is a minor under the age of 18)

Name _________________________________________ Phone ______________________

Date of Birth _______________SS# ___________________ Relationship _______________

◯ Contact information same as above

Address ______________________________ City _______________State _____ Zip ________

Phone ___________________________

Child Lives With: ◯ Mother ◯ Father ◯ Both ◯ Step-Parents ◯ Other __________

**Payment is due at the time of service**

**Consent to treat:** I authorize and consent to the treatment deemed necessary by the Physician for myself (or my child). Assignment of benefits: I authorize payment of benefits to Dr. Gould's office for the services rendered to me (or my child). I understand I am responsible for any costs not covered under my insurance plan. **NO GUARANTEE** of results of care & clinic's termination rights: I agree no one has promised or guaranteed any results of my (or my child's) medical care. I agree that nothing in this form prevents Dr. Gould's office from terminating my (or my child's) care with appropriate notice having been made.

**Signature:** __________________________________________________ **Date:** ___________________

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**Acknowledgment and Consent**

**Gregory E. Gould, D.O., P.C.**

I understand that Dr. Gould's office will use and disclose Health Information about me.

I understand that my Health Information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that "This Practice" may use and disclose my health information to:

- Make decisions about and plan for my care and treatment
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost effective health care.

I also understand that I have the right to receive and review a written description of how "This Practice" will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the health practices followed by the employees, staff, and other office personnel of "This Practice", and my rights regarding my health information.

I understand the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices in effect and a copy will also be posted in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that "This Practice" is not required by law to agree to such request.

**By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.**

Patient's Signature: ______________________________________ Date: _________________

Signature of Office Witness: _______________________________ Date: _________________

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# Adult Health History

Date ___________________

Patient's Name ____________________________ Date of Birth ________________ Age _______

General Health ____________________________________________________________________

Are you currently or have you ever been treated for (check all that apply)

| Yes | No | Condition | Explain |
|---|---|---|---|
| | | Asthma | |
| | | Bleeding Disorder | |
| | | Blood Pressure | |
| | | COPD | |
| | | Diabetes | |
| | | Ear/Sinus | |
| | | Fainting | |
| | | Gastro-Intestinal Problems | |
| | | Heart Disease | |
| | | Kidney Disease | |
| | | Learning Disorders | |
| | | Menstrual Problems | |
| | | Musculo-Skeletal | |
| | | Psychological/Psychiatric | |
| | | Seizures | |
| | | Sickle Cell Disease | |
| | | Sleep Disorders | |
| | | Stroke | |
| | | Surgery | |
| | | Thyroid Disease | |
| | | Serious Injury | |
| | | Other | |

**List all medications you are currently taking, including over-the-counter drugs and herbal supplements.**

**Allergies:** ____________________________________________________________________

| Medication | Dosage | Reason |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

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# Health Risk Assessment Form

## Gregory E. Gould, D.O. P.C.

**General**

Name: ________________________________ DOB: _________________ ◯ Male ◯ Female

Height: __________ Weight: _________ Race: ________

**Medical History**

Date of last check-up: ___________ Allergies: ____________________________________________
Medications: ____________________________________________________________________
Surgeries: ______________________________________________________________________
Cholesterol: _____________________________________________________________________
Injuries: _______________________________ Blood Pressure: ______________________________

**History of Self or family member**

◯ Cancer ◯ Diabetes ◯ Relation ___________
◯ Stroke ◯ Stroke ◯ Relation ___________
◯ Heart Disease ◯ Relation ___________
◯ Heart Attack ◯ Relation ___________
◯ Depression ◯ Relation ___________
◯ Bipolar Disorder ◯ Relation ___________

**Females**

Last date of most recent cycle _________
Date of last PAP Smear __________
Date of last breast exam _________
Date of last rectal exam _________
Year of last pregnancy _________
Did the pregnancy come to term? ◯ Yes ◯ No

**Males**

Date of last prostrate exam: _____________

**Exercise**

How many days per week do you work on cardio? _________________________________________
Length of time spent on cardio each session ____________________________________________
How many days per week do you work on strength? _______________________________________
Length of time spent on strength each session ___________________________________________
Injuries/conditions that interfere with exercise: ________________________________________

**Nutrition**

How many daily servings of vegetables do you eat? ◯ None ◯ 1-2 ◯ 3-4 ◯ 5-6 ◯ More
How many daily servings of fruit do you eat? ◯ None ◯ 1-2 ◯ 3-4 ◯ 5-6 ◯ More
How many daily servings of meat do you eat? ◯ None ◯ 1-2 ◯ 3-4 ◯ 5-6 ◯ More
How many daily servings of grains do you eat? ◯ None ◯ 1-2 ◯ 3-4 ◯ 5-6 ◯ More
How many servings of sugar/carbs do you eat? ◯ None ◯ 1-2 ◯ 3-4 ◯ 5-6 ◯ More

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**Primary Insurance**

Subscriber's Name ________________________________ Date of Birth ______________

◯ Male ◯ Female Employer _________________________ Phone ________________

Relationship to Patient: ◯ Self ◯ Spouse ◯ Parent ◯ Other

Insurance Name ______________________ Contact Number _________________________

Group # ___________________ PCP (If an HMO Insurance) ____________________________

**Secondary Insurance**

Subscriber's Name ________________________________ Date of Birth ______________

◯ Male ◯ Female Employer _________________________ Phone ________________

Relationship to Patient: ◯ Self ◯ Spouse ◯ Parent ◯ Other

Insurance Name ______________________ Contact Number _________________________

Group # ___________________ PCP (If an HMO Insurance) ____________________________

**Please provide office staff with your insurance cards to obtain copies for your records.**

**Release of Related Medical Records**

I authorize the release of my medical information needed to determine payment for services rendered. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges should they not be covered by my insurance company.

Patient's Signature ________________________________ Date ____________________

**Patient's Without Insurance Coverage:** If you are a cash patient without insurance, you will be required to pay for your office visit prior to seeing the physician. If other services are needed (blood work, x-rays, ect) payment in full is expected at the time of service. We accept payment in the form of cash or credit cards. Checks will only be accepted for insurance co-pay payments from established patients (excluding Medicaid).

Patient's Signature _____________________________ Date ________________

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**HIPPA Disclosure Form**

**Gregory E. Gould D.O. P.C.**

Patient's Name: ________________________________ Date: __________________________

Address: ______________________________________________________________________

Preferred Phone: _______________________ Email: _______________________________

Hospital:______________________________ Doctor: ______________________________

Would you like our correspondence with you to be marked "Confidential"? ◯ Yes ◯ No

May we identify ourselves over the phone? ◯ Yes ◯ No

May we leave messages for you on your phone? ◯ Yes ◯ No

I, the patient, hereby authorize the doctor and or hospital listed above to release my medical information (appointments, lab/x-ray results, diagnoses, treatments, medications, surgeries, ect.) via postal mail, telephone, fax, or email to the following family members:

Name: _______________________ DOB: _______________ Relationship: _________________

Name: _______________________ DOB: _______________ Relationship: _________________

Name: _______________________ DOB: _______________ Relationship: _________________

I further release my medical information to the following physicians, clinics, and or hospitals:

Doctor: ________________________ Clinic: _________________ Phone: __________________

Doctor: ________________________ Clinic: _________________ Phone: __________________

Doctor: ________________________ Clinic: _________________ Phone: __________________

Patient's Signature: _________________________________ Date: __________________

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**The Patient-Provider Partnership Agreement**

The health and wellness of our patients is top concern o this office. Providing the best possible care to every patient is our primary goal. The only way we can meet this goal is if I, your doctor, and you, my patient, work together. This concept is called the Patient Centered Medical Home.

**As our patient, your responsibilities are:**

- Ask questions, share your feelings and be part of your care
- Be honest about your history, symptoms and other important information about your health
- Tell your healthcare team about any changes in your health and wellbeing
- Take all of your medicine and follow your doctor's advice
- Make healthy decisions about your daily habits and lifestyle
- Prepare for and keep schedule visits or reschedule visits in advance whenever possible
- Call us first with all problems, unless it is a medical emergency
- End every visit with a clear understanding of your doctor's expectations, treatment goals, and future plans

**As your provider office, our responsibilities are:**

- Explain diseases, treatments, and results in an easy-to-understand way
- Take time to listen to your feelings and questions and help you make decisions you're their care
- Keep your treatments, discussions and records secure
- Provide 24-hour access to medical care and same day appointments, whenever possible
- Provide instructions on how to meet your health care needs when the office is not open
- To care for you to the best of my abilities based on my understanding of current medical methods available
- Provide you with clear directions about medicines and other treatments
- When necessary, direct and coordinate your care through referrals to specialists and community resources
- End every visit with clear instructions about expectations, treatment goals, and future

I look forward to our partnership,

Gregory E. Gould, D.O.

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Patient's Name: ________________________________ Birth Date: ____________________

Date: __________________

These questions are about your race, ethnicity, and primary language. We ask questions to make sure we are meeting the needs of all our patients.

1. Are you of Hispanic or Latino origin? **(please answer one)** ◯ No ◯ Yes ◯ Do Not Know ◯ Prefer not to answer
2. What is your race? **(You may select up to two races)**

◯ Black ◯ White ◯ Asian ◯ Native Hawaiian/Pacific Islander ◯ Do not know

◯ American Indian/Alaskan Native ◯ Other ◯ Prefer not to answer ◯ Unavailable

3. Please provide one nationality or ethnic group that best describes your ancestry. (for example, Italian, Jamaican, African American, Haitian, Korean, Lebanese, ect...) **(Please select one)**
   ◯ Hispanic/Latino ◯ Arab/American ◯ Other ◯ Do Not Know
   ◯ Unavailable ◯ Prefer Not to Answer

4. What language do you feel most comfortable using when discussing your health care? **(please answer one)**
   ◯ American Sign Language ◯ Hindi ◯ Urdu ◯ Arabic ◯ Chinese
   ◯ English ◯ Spanish ◯ Unavailable ◯ Prefer Not to Answer ◯ Hmong
   ◯ Do Not Know