New Patient Profile

Today's date: _____

Name: _____ (first) _____ (middle) _____ (last)

Sex: _____ Height: _____ Weight: _____

SS#: _____ Date of birth: _____ Marital status: _____

Home address: _____

City: _____ State: _____ Zip: _____

Mailing address: _____

City: _____ State: _____ Zip: _____

Home #: _____ OK to leave a message? _____ Work #: _____ OK to leave a message? _____

Mobile #: _____ OK to leave a message? _____ Email: _____ OK to leave a message? _____

Preferred method of contact: _____

Patient's employer: _____ Occupation: _____

Name of parents (if patient is a minor): _____

In case of emergency contact:

Name: _____ Relationship: _____

Home phone: _____ Business phone: _____

Tell us about you:

Your hobbies: _____ Your faith: _____

How did you find us: _____ Who referred you to us? _____

_____ _____

INSURANCE INFORMATION:

Responsible Individual: _____ Relationship to subscriber: _____

Insurance Company: _____ Group Number: _____

ID number: _____ Insurance phone: _____

PHARMACY INFORMATION:

Name & address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

CURRENT PRIMARY CARE:

Name & address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

YOUR MAJOR GOALS FOR THE FIRST VISIT: What you would like to accomplish on the first visit?

1) _____
2) _____
3) _____
4) _____

YOUR QUESTIONS: What questions do you have for today's visit?

_____
_____
_____

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Health Information (confidential)

PRESENT HEALTH CONCERNS: Please list three to five of your most important health concerns, in the order of their importance to you. (For example, #1 is most important and #3 is least important). The lines in this form are self-expanding — you are welcome to enter as much information as you feel is necessary.

Concern #1 - MAIN COMPLAINT	
How long have you had this problem?	
What makes it better?	
What makes it worse?	
What kinds of tests or exams have you had for it?	
What is the diagnosis?	
What kind of medications/supplements have you taken for it?	
Please elaborate, if necessary.	

Concern #2	
How long have you had this problem?	
What makes it better?	
What makes it worse?	
What kinds of tests or exams have you had for it?	
What is the diagnosis?	
What kind of medications/supplements have you taken for it?	
Please elaborate, if necessary.	

Concern #3	
How long have you had this problem?	
What makes it better?	
What makes it worse?	
What kinds of tests or exams have you had for it?	
What is the diagnosis?	
What kind of medications/supplements have you taken for it?	
Please elaborate, if necessary.	

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ALLERGIES: Please list all **food, environmental,** and/or **drug** allergies with reactions

_____

_____

_____

CURRENT MEDICATIONS:

NAME	**DOSE**	**FREQUENCY**: Times per day/ week/ month	**DURATION**: Been taking for how long?

CURRENT SUPPLEMENTS:

NAME	**DOSE**	**FREQUENCY**: Times per day/ week/ month	**DURATION**: Been taking for how long?

ROUTINE PROCEDURES: Check ones that apply and date

- ☐ Mammogram
- ☐ Dexa-Scan
- ☐ PAP Smear
- ☐ Colonoscopy

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MEDICAL HISTORY: Check ones that apply

☐ Diabetes	☐ Bronchitis	☐ Prostate Disease
☐ Anemia	☐ Pneumonia	☐ Incontinence
☐ Headaches	☐ Allergies/Hay fever	☐ Arthritis
☐ Nervousness	☐ Heartburn	☐ Neck and Back Pain
☐ Depression	☐ Abdominal Pain	☐ Osteoporosis
☐ Dizziness/Fainting	☐ Lactose Intolerance	☐ Gout
☐ Stroke	☐ Bowel Irregularity	☐ Chronic Rashes
☐ Heart Palpitations	☐ Gall Bladder Disease	☐ Rheumatic Fever
☐ Chest Pain	☐ Hepatitis	☐ Prolactinoma
☐ Myocardial Infarction	☐ Sexual/Menstrual dysdunction	☐ Peripheral vascular disease
☐ Short of Breath	☐ Sexually Transmitted Disease	☐ HIV
☐ Asthma	☐ Chronic infections	☐ Cancer
☐ Other	☐	☐

PROCEDURE HISTORY: Please list all previous **medical procedures**, **surgeries**, **hospitalizations**, & **serious illnesses.**

Approximate date/ year	Surgery / hospitalizations / procedures / serious illnesses / injuries

FAMILY HISTORY:

1. **FATHER:** _____
2. **MOTHER:** _____
3. **SIBLINGS:** _____
4. **OTHER:** _____

MEN ONLY: It's common for men to occasionally experience erectile difficulties.

Is this something that happens to you?

How often does it happen to you?

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DIET: Do you follow any particular diet regimens or restrictions?

EXERCISE: Do you exercise regularly? If YES—what do you do? If NO—what keeps you from exercising?

☐ Yes. What kind of exercise do you do?

☐ No. What keeps you from exercising?

HABITS and LIFESTYLE: Which of the following do you use?

☐ Current Smoker	☐ Cola/soda	☐ Recreational drugs
☐ Former Smoker	☐ Black tea	☐ Prescription drugs
☐ Alcohol	☐ Coffee	

SLEEP:

Difficulty falling asleep:

How many hours do you sleep every night?

Snoring?

Early morning awakening?

OTHER ADDITIONAL INFORMATION:

Office Policies for The Grossgold Clinic (1001 S. Ft Harrison Ave #200)

The following information is provided to enable our sharing of a common understanding of our rights and roles in this professional therapeutic relationship. Please read this agreement and sign at the end indicating that you have understood and agreed to the following. Please ask any questions if you would like clarification or additional information.

- Although Dr. Grossgold's wish is to care for his patients as a family physician, in reality, he is a consulting specialist in holistic medicine. Constant pursuit of knowledge and willingness to share that knowledge make frequent out of town travel a necessity. Dr. Grossgold is generally unavailable except by appointment, and he has no coverage when he is not available. We therefore request that our patients keep their former physician as a back-up in case of emergencies.
- Payment is due at the time of the visit. As a courtesy, we will provide you with a statement which is necessary to file an insurance claim. Please keep a copy for your records before sending the original to your insurance company. Your insurance is a contract between you and your insurer, and we do not get involved in any disputes between the two of you.
- We charge for our time as other professionals do. For services such a phone consultations, prescription refills, medical reports and letters, there will be a charge of $35.00 or $5.00 per minute, whichever is more. We bill for the amount of time it takes to provide the service.
- If a promotional price was given to you, this will be verified by the office and will be for the initial consultation only, or what was promised at the event or time of scheduling
- We do not overbook. A time slot is reserved especially for you when you schedule an appointment. If you need to cancel or to reschedule an appointment, we require 24 hours advance notice, otherwise that slot goes to waste. Cancellations made with less than the required 24 hours will be charged for $100 for the missed appointment.

Fee Schedule

- Payment is due at the time of the visit.
- We charge for our time as other professionals do. Our fee schedule is as follows:
    - Our standard rate visits is $6/minute of face-to-face time with the physician. You are not charged for time spent by our assistants when measuring your vitals and/or collecting histories. New patient visit is $360. Rates are subject to change at any time without prior notice, so please inquire directly for our latest rates.
    - Scheduled phone or video consults with our physicians are considered equivalent to face-to-face visits, and are therefore billed the same as office visits.
    - In-office procedures such as I.V.'s, labs, injections, etc are billed in addition to the hourly rate. We work diligently with our labs and suppliers to keep our prices as low as possible, and therefore you will find our fees to be highly competitive.
    - Additional services such as after-hours phone consultations, prescription refills, medical reports, and letters will be a charged either $6.00 per minute or $35.00, whichever is greater. We bill for the amount of time it takes to provide the service. For example, a 10 minute after-hours phone consult that requires an additional 5 minutes of the physician's time to send a prescription will result in a charge for 15 minutes, or $90.

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Office Policy Agreement

- I have read and understood the office policies above.
- I understand that Dr. Grossgold practices integrative, complementary, alternative medicine at the Grossgold Clinic. I have come to see Dr. Grossgold because I prefer alternative methods to "conventional treatment" as defined by the AMA and the Florida Board of Medical Examiners.
- Because of the nature and scope of our practice, we are a Direct-Pay practice and we DO NOT accept insurance at this location. As a courtesy, we will provide you with a statement which is necessary for you to file an insurance claim with your provider. Your insurance is a contract between you and your insurer, and we do not get involved in any disputes between the two of you.
- Any refunds for services yet to be provided, as well as those already delivered will be viewed and determined on a case by case basis without promise of recompense. Refunds for patients yet to receive service will be charged 40% of the securing price and the remaining to be individually reviewed and dispersed at the Doctor's discretion. Ultimately, Dr. Grossgold will treat all patients fairly and with respect in regards to healthcare payment and reimbursement. o I agree to pay for missed appointments and/or appointments cancelled with less than 24 hours' notice.

Name (Printed): _____ Signature: _____ Date: _____

Office Policies for Gold Primary Care (401 Corbett St, Suite #340)

The following information is provided to enable our sharing of a common understanding of our rights and roles in this professional therapeutic relationship. Please read this agreement and sign at the end indicating that you have understood and agreed to the following. Please ask any questions if you would like clarification or additional information.

I. PAYMENTS
- *a.* Payments are due, for self-patients, prior to you seen the provider.
- *b.* Co-Payments are due, for patients with insurance, prior to you seen the provider.

II. INSURANCE
- a. Our office will attempt to verify your insurance prior to your visit. However, you are responsible to inform us of any coverage change that have taken place.
- b. If your insurance plan requires a designation of primary care physician, you are required to make sure that physician you are seeing is listed as our primary care on your insurance card. If you are seen in the office and we are not your primary care you will be responsible for the charges incurred at your visit.
- c. You are responsible for knowing what your insurance will or will not cover.
  - i. If you are unsure, please speak with our billing department prior to services being rendered. Our Billing department contact number is: 407-302-4606.
  - ii. The statements of our billing department will be the mest up to date information provided by your insurance company, and will not be a guarantee of payment. Your insurance company will make final coverage determination after the srvices are rendered.

III. MISSED APPOINTMENTS
- a. New pstient's appointments will not be reacheduled if you do not show up to your first scheduled visit. Our office reserves the right to bill you up to $100.00 for this no show.
- b. Established patienits will be charge a $25.00 no show fee for:
  - i. Failure to show up for shceduled appointment.
  - ii. Cancellation of an appointment whitout a 24h notice.

Name (Printed): _____ Signature: _____ Date: _____