Michael P. Golden, M.D., P.A NEW PATIENT INFORMATION

PLEASE PRINT ALL IN			TODAT 5 DA	1E:	
PATIENT INFORMATION	<u> </u>				
PATIENT'S NAME:		Middle		Last	
	ATIENT'S ADDRESS:				
TATIENT S ADDRESS.					
_	City	Stat	e	Zip Code	
PATIENT'S HOME#:		CELL#:	WORK#	:	
PATIENT'S DRIVERS LIC	CENSE#/STATE:				
PATIENT SOCIAL SECURITY#:			MEDICARE#:		
PATIENT'S DATE OF BIR	RTH:	AGE:	MALE /	FEMALE (Please circle one)	
IF PATIENT IS A STUDEN	NT (Please check one)		FULL TIME	PART TIME	
PATIENT'S MARITAL ST	`ATUS (Please circle o	one): Single M	larried Divorced	Separated Widowed	
SPOUSE'S NAME:		CON	VTACT#:		
PATIENT'S EMAIL ADDI	RESS:				
PATIENT'S OCCUPATION:		EM	EMPLOYER:		
RESPONSIBLE PARTY IN	NFORMATION (If dif	ferent than above)			
NAME.			HOME#•		
NAME:First	Middle	Last			
ADDRESS:			CEDE#		
ADDRESS.					
	City	State		Zip Code	
REFERRING DOCTOR:_			OFFICE#:		
			FAX#:		
REASON FOR TODAY'S	VISIT:				
TREATMENT YOU HAVE	E USED FOR THIS PI	ROBLEM:			

PLEASE LIST ALL ALLERGIES TO MEDICINES:
CIRCLE MEDICATION YOU ARE TAKING OR OCCASIONALLY TAKE: (PLEASE CIRCLE ALL THAT APPLY)
ANTIBIOTICS ASPIRIN STOMACH MEDICINE VITAMINS IRON BIRTH CONTROL PILL
LAXATIVES BLOOD THINNERS HEART MEDICINE TRANQUILIZERS BLOOD PRESSURE MEDICINE
SLEEPING PILLS
OTHERS:
HAVE YOU HAD ANY OF THE FOLLOWING: (PLEASE CIRCLE ALL THAT APPLY)
X-RAY TREATMENTS TB CANCER BAD SCARS CHICKEN POX ULCERS OR INTESTINAL DISEASES
HIGH BLOOD PRESSURE BLEEDING TENDENCY DIABETES ANEMIA SEIZURES HEART DISEASE
LIVER DISEASE KIDNEY DISEASE
HABITS:
DO YOU USE TOBACCO NOW? HOW OFTEN?
DO YOU USE ALCOHOL NOW? HOW OFTEN?
DO YOU USE RECREATIONAL DRUGS?
DO YOU EXERCISE REGULARLY?PLEASE DESCRIBE
DO YOU FOLLOW ANY SPECIAL DIET? (low cholesterol)
WOMEN ONLY:
ARE YOU OR COULD YOU BE PREGNANT AT THIS TIME?
DO YOU PLAN ON BECOMING PREGNANT IN THE NEAR FUTURE?

INSURANCE INFORMATION: INSURANCE COMPANY NAME: NAME OF SUBSCRIBER/INSURED:__ SUBSCRIBER/INSURED SOCIAL SECURITY# AND ID #: SUBSCRIBER/INSURED DATE OF BIRTH:___ Month GROUP OR POLICY #: I, the undersigned (patient or legal guardian), authorize medical and/or surgical treatment to be rendered by Doctor Golden and his staff. In addition, I hereby authorize my insurance benefits to be paid directly to Doctor Golden, realizing I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers. Also in addition, due to contract language between the physician and the insurance company, I understand that I am financially responsible for all charges deemed to be "non-covered benefits" by my insurance company even if the insurance's Explanation of Benefits state that the procedure is a "non-covered benefit" and "patient is not responsible". Signature: (Patient or Legal Guardian) Date signed:

METHOD OF PAYMENT: CASH CHECK MASTER CARD/VISA (PLEASE CIRCLE ONE)

AUTHORIZATION TO RELEASE PATIENT INFORMATION

I authorize Michael P. Golden, M.D., P.A., and/or its member physicians, Michael P. Golden, to release and furnish on a confidential and a strict need to know basis all medical and financial data related to my care that may be necessary now or in the future to facilitate payment by third parties for services rendered by Physician, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's and PPO's managed care organizations, IPA's, Medicare/Medicaid or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions. I also give my authorization to have a copy of my medical records delivered to a primary physician or any other physician that is directly or indirectly responsible for my medical care or the payment thereof.

Date:		
Patient Name:		
Patient or Legal Guardian Signature:		