Michael M. Gottlieb, M.D., FACS

Patient Information Sheet

Please provide complete information so that we may bill your insurance.

First Name	Last Name	MI	Today's Date

Street Address	Apt. #:	City	State	Zip

Home Phone	Work Phone	Cell Phone

Social Security #	Date Of Birth	Sex: M F	Age

Marital status (circle one):	Work status (circle one):	Student status (circle one):
Married Single Widowed Divorced Life Partner	Full Time Part Time Retired Disabled None	Full Time Part Time None

Occupation	

Employer's Name	Employer's Phone Number

Emergency Contact Name	Phone Number

Who referred you to our office?

Who is your Primary Physician?

Reason for Visit:

Are you in an HMO? (ex: Hill Physicians IPA, Muir/Diablo IPA)?

Primary Insurance

Insurance Company Name		

Address		

City	State	Zip

Policy #	Group#

Subscriber's Name

Subscriber's Employer & Phone Number

Subscriber's Date of Birth	Subscriber's Sex: M F

Your Relationship to Subscriber?
Self Spouse Child

Secondary Insurance

Insurance Company Name		

Address		

City	State	Zip

Policy #	Group#

Subscriber's Name

Subscriber's Employer & Phone Number

Subscriber's Date of Birth	Subscriber's Sex: M F

Your Relationship to Subscriber?
Self Spouse Child

Please give all insurance cards and forms to the receptionist to be copied.

I certify that the above information is true and accurate.

Signature	Date

Michael M. Gottlieb, M.D., FACS

FINANCIAL RESPONSIBILITY FORM

Assignment of Benefits

PLEASE READ CAREFULLY BEFORE SIGNING

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ALL INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED.

- I assign all medical and / or surgical benefits, including major medical benefits to which I am entitled, to Michael Gottlieb, M.D., and I authorize payment directly to Michael Gottlieb, M.D.. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.
- I understand that if I receive any payments due to Michael Gottlieb, M.D., it is my responsibility / obligation to immediately remit the payments to Michael Gottlieb, M.D.. I further realize that if I fail to do so, I am responsible for the bill in its entirety.
- If my insurance benefits are canceled, and I continue to receive services, I agree to pay all bills in full.
- I also agree to cooperate with my insurance company in submitting all forms they request. Should I fail to do so, and thus payment is denied, I agree to pay the bill in its entirety.
- INSURANCE COVERAGE does not necessarily mean FULL coverage, and I understand that I am personally responsible for all co-payments and deductibles.

I/We further agree that the account may be placed for collection when it becomes 30 days past due. I hereby acknowledge that I have read the above, or have had the above read to me and that I understand the terms of this agreement.

PATIENT'S SIGNATURE _____ **DATE** _____

INSURED'S SIGNATURE _____ **DATE** _____

MEDICARE PATIENTS:

- I request that payment of Medicare benefits be made to Michael Gottlieb, M.D. for any services furnished to me by that physician.
- I request that payment of Medigap or supplemental insurance benefits, if any, be made to Michael Gottlieb, M.D. for any services furnished to me by that physician.
- I permit a copy of this form to be used in place of the original. This form is in effect until I choose to revoke it.

PATIENT'S SIGNATURE _____ **DATE** _____

HEALTH HISTORY

Michael M. Gottlieb, M.D., FACS

Name: _____ D.O.B.: _____ Height: _____ Weight: _____

PAST MEDICAL HISTORY:

List Surgery you have had: None _____

_____

List Your Medical Problems: None _____

_____

_____

Last Colonoscopy: Never When? _____ Any polyps? No Yes

MEDICATIONS: (List Everything you take): _____

Any Aspirin or Excedrin? No Yes _____

Any Herbal Medications? No Yes _____

ALLERGIES TO MEDICATIONS (OR FOODS):

None Yes List: _____

REVIEW OF SYSTEMS: (Have you ever had Problems with...?)

Brain / Stroke / Seizure	No	Yes	Explain:
Head / Eyes / Ears / Nose	No	Yes	Explain:
Throat / Neck / Thyroid	No	Yes	Explain:
Lungs / Short of Breath	No	Yes	Explain:
Heart / Chest Pains	No	Yes	Explain:
High Blood Pressure	No	Yes	Explain:
Bleeding / Bruising	No	Yes	Explain:
Stomach / Intestines	No	Yes	Explain:
Kidneys / Bladder	No	Yes	Explain:
Sex Organs	No	Yes	Explain:
Muscles / Bones	No	Yes	Explain:
Skin	No	Yes	Explain:
Anxiety / Depression	No	Yes	Explain:
Weight change (loss/gain)	No	Yes	Explain:
Swelling in Ankles/Legs	No	Yes	Explain:
Diabetes	No	Yes	Explain:
Anesthesia	No	Yes	Explain:
Other	No	Yes	Explain:

SOCIAL HISTORY:

Alcoholic Beverages: Never Quit (when?) _____ Yes How Much? _____

Tobacco: Never Quit (when?) _____ Yes How Much? _____

Drugs: Never Quit (when?) _____ Yes List: _____

Are you sexually active? No Yes

What is your job? _____

FAMILY HISTORY: (Has anyone in your family had…?)

Breast Cancer	No	Yes	Who?
Ovarian Cancer	No	Yes	Who?
Colon Cancer	No	Yes	Who?
Colon Polyps	No	Yes	Who?
Other Cancers	No	Yes	Who?
Heart disease	No	Yes	Who?
Diabetes	No	Yes	Who?
Stroke	No	Yes	Who?
Bleeding	No	Yes	Who?

PATIENT SIGNATURE: _____ DATE: _____

DOCTOR SIGNATURE: _____ DATE: _____

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RECEIPT OF PRIVACY NOTICE

Your signature below states that you have received a copy of our practice's privacy notice. This acknowledgement will be kept in your chart.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed Name Date of Birth

_____
Personal Representative's relationship to the patient: