Michael T. Margolis M.D

101 S SAN MATEO DR STE 10
SAN MATEO, CA 94401
650-375-1644

825 POLLARD RD
LOS GATOS, CA 95032
408-370-9098

Patient Information Form

Patient Name: _____ **Date of Birth:** _____ **Marital Status:** S M W D

Address: _____ **City:** _____ **ST:** _____ **Zip:** _____

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

SSN: _____ - _____ - _____ **Email:** _____

Employer: _____ Primary Language: _____

Race: _____ Ethnicity: _____

Circle if okay to leave a message at: **Home** **Cell** **Work**

****Emergency Contact****

Name: _____ Phone: _____ Relation: _____

Pharmacy Information

Pharmacy: _____ Address: _____ City: _____

Pharmacy Phone Number: _____ Fax: _____

Referring Physician: _____ Phone: _____

Primary Physician: _____ Phone: _____

Preferred Lab: QUEST LABCORP OTHER _____

THE FOLLOWING MUST BE COMPLETED ALONG WITH BRINGING IN YOUR INSURANCE CARD

Primary Insurance Carrier: _____

ID#: _____ **Group#:** _____ Effective Date: _____

Insured's Name: _____ Insured's Employer: _____

Insured's SSN: _____ - _____ - _____ Insured's DOB: _____

Claim Address: _____ City: _____ ST: _____ Zip: _____

Relationship to Insured: SELF SPOUSE CHILD OTHER

Secondary Insurance Carrier: _____

ID#: _____ **Group#:** _____ Effective Date: _____

Insured's Name: _____ Insured's Employer: _____

Insured's SSN: _____ - _____ - _____ Insured's DOB: _____

Claim Address: _____ City: _____ ST: _____ Zip: _____

Relationship to Insured: SELF SPOUSE CHILD OTHER

PATIENT SIGNATURE: _____ DATE: _____

Michael T. Margolis M.D

101 S SAN MATEO DR STE 10
SAN MATEO, CA 94401
650-375-1644

825 POLLARD RD
LOS GATOS, CA 95032
408-370-9098

Patient Consent/Agreement form

Name: _____ **DOB:** _____

CONSENT FOR TREATMENT
I hereby consent to examination and the performance of all treatments that may be considered medically necessary or advisable. This may include the administration of needed Anesthetics, the use of prescribed Medication, the use of Diagnostic Procedures and the use of X-ray, and Laboratory tests.

Release of Information
I authorize the release of any medical information to and from any medical facilities, physician, and/or my insurance company. I also authorize the following persons to receive any medical information.

_____

_____

_____

Privacy Policy Acknowledgement
I acknowledge that I have been given ***The Notice of Privacy Practice*** for the office of Dr. Michael T. Margolis M.D.

Payment
I understand that I am responsible for payments for services including co-payments, balances and charges for services not covered by insurance. All Payments are due at the time of service. I authorize the payment of insurance benefits to Michael Margolis M.D.

Referral/Authorizations
I agree to provide a referral or an authorization from my Primary Care Physician or referring Physician if my insurance is an HMO at the time of my visit. If no referral form is provided, you visit may be re-scheduled.

Medical Record Copies
The coping of medical records incurs a $50.00 charge and will not completed without payment.

Change of Address and/or Insurance
I agree to notify Dr. Margolis' office of any changes to my address, phone number, employment and insurance. I have read all the above information on this sheet and have agreed that (regardless of my insurance) I will pay for all Medical Services provided by Michael Margolis M.D or any health care professional acting on their behalf. I agree that unpaid insurance balances are my full responsibility.

Medi-Cal Agreement
I declare the I DO NOT have Medi-Cal as my primary insurance or a secondary insurance. I understand that Dr. Margolis is NOT a contracted provider for Medi-cal. I understand I will be financially responsible for services provided by Dr. Margolis if I have Medi-Cal Insurance.

Signature: _____ **Date:** _____

Today's Date_____

Michael T. Margolis M.D
Patient Health Assessment

Patient Name:_____ **Date of Birth:**_____

Reason for Today's Visit_____

Primary Care Physician: _____ **Phone:** _____

Gynecologist: _____ **Phone:** _____

Cardiologist: _____ **Phone:** _____

Pain Management Doctor:_____ **Phone:**_____

Height:_____ Weight: _____ B/P:_____ Pulse:_____

MEDICATION LIST

Name	Dose	Reason

ALLERGIES

NAME	REACTION

PREVIOUS HEALTH SCREENING TEST

NAME OF TEST	DATE	RESULT
Mammogram		
EKG		
PAP		

PREVIOUS SURGERIES/RADIATION/CHEMOTHERAPY

Procedure	Date	Type of Anesthesia	Complications Y/N

OB History

Number of pregnancies_____

Number of deliveries _____ **term** _____ **preterm** _____ **live birth**

Number of miscarriage _____ **abortion** _____**multiple** _____**ectopic**

Sexual History

Sexually active **Y** **N**

Birth Control/Protection type _____

Cancer History

Self	Yes/No	Type
Family History of Cancer	**Maternal/Paternal**	**Type of Cancer**

Social History

Do you use recreational drugs? (i.e. Marijuana, cocaine, Opiates etc....) Y N

If so, please list types _____

Are you a current or former smoker? Packs a day/Date Quit_____ Y N

_____

Do you drink alcohol? Drinks per day? _____ Y N