Mardi R. Karin, M.D., Jeffrey J. Gutman, M.D.,
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14850 Los Gatos Boulevard, Los Gatos, CA 95032

PATIENT INFORMATION (Please type in form then print and bring to appointment)

Name: ______________________________ Referring Doctor: ______________________________

Birthdate: ____________________ Age: ____________ Primary Care Doctor: ______________________________

Social Security # ______________ Other Doctor(s) ______________________________

Address: ______________________________ City ____________________ State______ Zip ____________

Email: ______________________________ Sex: Male Female

Home Phone: ____________ OK to leave a message? YES NO

Cell Phone: ____________ OK to leave a message? YES NO

Work Phone: ____________ OK to leave a message? YES NO Employer: ____________________

Marital Status: ________ Spouse Name: ______________________ Phone #: ______________________

Is it ok to share **YOUR** MEDICAL INFORMATION with your SPOUSE? YES NO

OTHERS with whom we may share **YOUR** MEDICAL INFORMATION: (list parents if patient is a minor)

Name 1: ______________________ Relation: __________________ Phone:________________

Name 2: ______________________ Relation: __________________ Phone:________________

Are you here because of a Work related injury? YES NO **If yes, date of Injury** ____________________

Fill this out if the SUBSCRIBER of your insurance is someone other than you.

Subscriber's Full Name: ______________________________ Relationship to Patient ____________

Social Security # __________________ Birthdate: ________________ Cell#: ______________________

Employer ______________________________ Work#: ______________________

Agreement to Pay: I agree to pay for all medical services rendered.
Payment and Interest: Payment in full for medical services is due upon receipt of statement. Interest shall be charged to all overdue accounts at the rate of 12% per annum or 1% per month.
Insurance: As a courtesy, our office will file all insurance claims. We will allow 45 days for payment from your insurance company. After that, you are responsible for payment in full.
Attorney's Fees: In the event legal action should become necessary to enforce payment of any charges, the undersigned agrees to accept all financial responsibility for fees associated with the collections process, court costs, and reasonable attorney's fees in addition to any relief granted by the court.
Authorization to release information and pay benefits to physician: I hereby authorize payment directly to the physician of surgical and/or medical benefits, if any, otherwise payable to me for his/her services as described herein, and to release any information acquired in the course of my examination or treatment to hospital, other physicians, and/or my insurance company.

I have read the above, understand my responsibility and agree to abide by all the terms and conditions. I have also been presented with the **NOTICE OF PRIVACY PRACTICES.**

Signature:______________________________ Date: ______________________