PATIENT INFORMATION FORM

Date of Birth: ____________

Name: ____ SSN: ________________
(LAST) (FIRST) (M.I.)
Home Address: ____________________________________ Phone #: ________________
City: ________________ State ___ Zip ____________ Driver's License # ________________

Alternate Phone # (cell)_______________ Email ____________________________________
Gender MALE ( ) FEMALE ( ) Marital Status: ( ) Married ( ) Single ( ) Div ( ) Sep ( ) Widow (er)

Employer Name: ______________________________ Occupation ____________________
Address: ____________________________________ Phone #: ______________________
May we call you at work? ( ) Yes ( ) No

RESPONSIBLE PARTY FOR PAYMENT (IF OTHER THEN PATIENT):
Name: ____________________________ DOB _______________ SSN ________________
Address: ____ Phone # __________________
Employer: _______________________________________ Phone # __________________
Address: ____

REFERRING PHYSICIAN ____

INSURANCE INFORMATION

PRIMARY INSURANCE _________________________ SUBSCRIBER ___________________
SECONDARY INSURANCE _______________________ SUBSCRIBER ___________________

MEDICARE? ( ) YES ( ) NO IF YES, IS MEDICARE ( ) PRIMARY OR ( ) SECONDARY
IF MEDICARE IS PRIMARY, DO YOU HAVE A SECONDARY INSURANCE PLAN? ( ) YES ( ) NO
IF YES, IS THIS PLAN A MEDI-GAP OR EMPLOYER SUPPLEMENT (CIRCLE ONE)

IF YOU ARE COVERED BY MEDICARE AND YOU OR YOUR SPOUSE ARE STILL WORKING PLEASE COMPLETE:

ARE YOU EMPLOYED FULL TIME? ______ OR PART TIME? ________
IS YOUR SPOUSE EMPLYOED FULL TIME? _______ OR PART TIME? ________
ARE YOU OR YOUR SPOUSE ELIGIBLE FOR GROUP HEALTH INSURANCE THROUGH EMPLOYER? ( ) YES ( ) NO
IF YES, INSURANCE COMPANY NAME: ________________________________
SUBSCRIBER: ________________________________

I, THE UNDERSIGNED, HAVE INSURANCE COVERAGE WITH ________________________
(INSURANCE COMPANY)
AND ASSIGN DIRECTLY TO DAVID H.Y. LIN, M.D. ALL SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. IN UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE DAVID H.Y. LIN, M.D. TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS.

DATE:_______________ SIGNED: ____

DISCLAIMER

Dr. Lin has financial interest in the Laser Surgery Center. If such an interest is of concern to you, please feel free to discuss this with Dr. Lin or the staff.

PERSONAL HISTORY

Check if you have the following:

Rheumatic Heart Disease	____	High Blood Pressure	____	Kidney/Bladder Stone	____
Heart Attack	____	Arthritis/Rheumatism	____	Prostate Trouble	____
Pneumonia	____	Bone or Joint Disease	____	Gonorrhea/Syphillis	____
Tuberculosis	____	Bursitis/Sciatica	____	Stomach Ulcer	____
Pleurisy	____	Epilepsy	____	Liver or Gallbladder disease	____
Bronchitis	____	Migraine Headaches	____	Colitis or bowel disease	____
Asthma	____	Stroke	____	Jaundice/Hepatitis	____
Emphysema	____	Neuritis	____	Blood in stools	____
Hay Fever/Eczema	____	Skin Disease	____	Colonic Polyps	____
Cancer	____	Pancreatic Disease	____	Diabetes	____
Kidney Disease	____				

Allergies: (Including allergies to medications and chemicals)

Previous Surgery: (Specify type and date)

Previous injuries or trauma: (Specify type of injury and date)

Recent tests: (Please include x-rays, skin tests, EKG's, Laboratory tests, etc.)

Medication presently being taken (include milligram strength and directions)

Habits: (Smoking, Alcohol intake, etc.)
If you are a smoker, please indicate how many packs per week and duration of smoking habit:

Background history: (Place of birth, education, occupation, etc.)

Ethnicity:

White	____	Black or African American	____	Black Hispanic or Latino	____
American Indian	____	Alaskan Native	____	White Hispanic or Latino	____
Native Hawaiian	____	Other Asian	____	Filipino	____
Other Pacific Island	____	Japanese	____	Chinese	____
Korean	____	Samoan	____	Tongan	____
Guamanian	____	Vietnamese	____	Unknown	____

Preferred Language: ____________________

Name: ______________________________

REVIEW OF SYSTEMS

Eye Disease	____	Cough: frequent	____	Chest Pain	____
Eye Injury	____	chronic	____	or pressure	____
Impaired Sight	____	productive?	____	Angina pectoris	____
Ear Disease	____	color	____	Palpitations	____
Impaired Hearing	____	blood	____	Swelling of feet	____
Any trouble w/ nose	____	Vomiting of blood	____	ankle	____
w/ mouth	____	Rectal bleeding	____	abdomen	____
w/ throat	____	Hemorrhoids	____	Blood in urine	____
Fainting Spells	____	Black tarry stools	____	albumin	____
Convulsions	____	Bloody stools	____	sugar	____
Paralysis	____	Constipation	____	Difficulty starting urination	____
Dizziness	____	Diarrhea	____	or narrowed stream	____
Headaches: frequent	____	Change in appetite	____	Burning on urination	____
Severe	____	Change in eating habits	____	Abnormal thirst	____
Enlarged glands	____	Change in bowel habits	____	Recent weight loss	____
Thyroid:		Shortness of breath	____	Abdominal pain	____
Overactive	____	on exertion	____	gas	____
Underactive	____	at night	____	belching	____
Enlarged	____	Wheezing	____	indigestion	____
Enlarged goiter	____			Difficulty swallowing	____

Date of last 1. Influenza vaccine________ 2. Pneumonia vaccine________ 3. Bone density________

FAMILY HISTORY

Mother: age ___ If deceased, age at death ___ Cause of death ____________________________

Father: age ___ If deceased, age at death ___ Cause of death ____________________________

Brothers, sisters: List ages. If deceased, age at death and cause of death ____________________

____

Children: List ages. If deceased, age at death and cause of death __________________________

____

IS THERE ANY FAMILY HISTORY OF THE FOLLOWING? IF SO, PLEASE STATE WHICH FAMILY MEMBER.

Cancer__________	Tuberculosis__________	Blood disease____________
Diabetes__________	High Blood Pressure__________	Hepatitis_______________
Heart trouble ________	Asthma, hives, hay fever _________	Colonic Polyps ___________
Crohn's disease_______	Ulcerative Colitis___________	Peptic Ulcers____________

Patient's Name ______________________

David H.Y. Lin, Ph.D., M.D.
Gastroenterology – Internal Medicine
Diplomate American Board of Internal Medicine and Gastroenterology

905 San Ramon Valley Blvd., Suite 206
Danville, CA 94526

Tel. (925) 831-920C
Fax. (925) 831-931'

FINANCIAL POLICY

INSURANCE – CASH PATIENTS

Patients are financially responsible for services provided and are expected to pay at the time of service. As a courtesy, we will bill your insurance; however, you will need to provide complete billing information at the time of your visit. A copy of your charges, if requested, will be supplied to you so that you may follow up with your insurance company personally.

HMO-PPO PATIENTS

If you are a member of an HMO/PPO, you are required by your health plan to pay a co-payment at the time of your visit. We cannot waive the co-payment amount as a contracted provider. the Co-payments will be collected at time of service. Non-covered services must be paid at the time of the service.

MEDICARE

We are participating providers in Medicare, which means that we accept Medicare assignment and accept Medicare's allowable amount as payment in full, once your deductible and co-payments have been made. We will bill MediCare for you, as well as your supplemental insurance. You must provide us with valid cards from MediCare and other insurance. Without these documents we cannot bill your insurance and payment will be expected from you at the time of your visit. Deductibles will be paid at the time of service.

CANCELLATIONS – NO SHOWS

If you are scheduled to see Dr. Lin and are unable to keep your appointment, please contact our office as soon as possible so we may schedule your time for another patient. If you cancel appointments with less than 24 hours' notice (48 hours' notice for procedures), you may be subject to a charge consistent with the time allowed for the visit. Failure to show up for your appointment creates gaps in our schedule and affects our ability to provide appropriate care to all our patients. "No Shows" and/or cancellations of office visits with less than 24 hours' notice will result in a minimum charge of $25.00. "No Shows" and/or cancellations of procedures with less than 48 hours' notice will result in a minimum charge of $100.00. This charge is NOT covered by your insurance company. Repeated "No Shows" or cancelled appointments, without at least 24 hours' notice, may be cause for dismissal from our practice.

COMPLETION OF FORMS/PHOTOCOPYING OF MEDICAL RECORDS

A minimum charge of $25.00 will be charged with a maximum of $100.00.

If you are experiencing financial hardship, please ask to speak with our office manager regarding a payment plan.

A $25.00 charge will be applied for returned checks.

Signed:____________________________________

Date:_____________________________________

I acknowledge I have read the above financial policy

David H. Y. Lin M.D.
Gastroenterology
905 San Ramon Valley Blvd., Suite 206
Danville, CA 94526

HIPAA Privacy Authorization Form

Authorization for use Or Disclosure of Protected Health Information

Acknowledgement Of Receipt Of Notice Of Privacy Practice

1. Authorization

I authorize Dr. David H.Y. Lin, M.D. to use and disclose the protected health information as needed.

2. Effective Period

This authorization for release of information covers the period of

☐ ONE YEAR

OR

b. ______ All past, Present, and Future periods.

3. Extend of Authorization

1. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

2. I understand that I have the right to revoke this authorization in writing at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

X____ DATE______________

SIGNATURE OF PATIENT OR PERSON REPRESENTING PATIENT

X____DATE______________

PRINT NAME OF PATIENT OR PERSON REPRESENTING PATIENT

David H. Y. Lin M.D.
Gastroenterology
905 San Ramon Valley Blvd., Suite 206
Danville, CA 94526

HIPAA CONSENT
CONSENT TO LEAVE MESSAGES

Patient Name:______________________________ Date:____________________
(print)

I wish to be called at home☐ ; cell☐; other☐ (check all that apply) regarding my care and follow-up. The best telephone number(s) to reach me are:

______________________________home ______________________________cell

______________________________other

I do☐, I do not☐ give permission to leave relevant medical information on my answering machine or voice mail.

I do☐, I do not☐ want relevant medical information shared with the person who may answer the telephone. The name(s) of the individual(s) with whom you may leave pertinent information are:

____

____

______________________________ ____________________
Patient Signature Date