Chart #: _____

GEORGE R. GOTTLIEB, M.D., P.C.

Date: _____ Age: _____ Birth Date: _____ (MM/DD/ YY) Marital Status: S M W D Sep. (Please circle one) Male / Female (Please circle one)

Full Name: _____ (Last First Middle) Social Security No. _____

Home Address: _____

Telephone No. _____ County: _____

Your Employer: _____ Occupation: _____

Employment Address: _____ Employment Phone No.: _____

Person Responsible for Bill: _____ Relation: _____

Home Address: _____ Telephone No.: _____

Employed by: _____ Address: _____ Occupation: _____

Employment Phone No.: _____

In case of emergency, nearest relative, neighbor, or friend: _____ Telephone No.: _____

Referred by: _____

Primary Care Physician: _____ Physicians seen past two years: _____

_____

PAYMENT OF FEES

We are trying hard to contain the costs of medical care and avoid fee increases as much as possible. Because the cost of billing has become so very expensive, we are asking your cooperation in keeping costs down by coming to the office prepared to pay for services rendered. Please discuss with doctor and/or office manager any special hardships, such as personal or family illness, unemployment, etc.

I authorize the release of any medical information necessary to process insurance claims.

I understand that I am financially responsible for all charges whether or not paid by said insurance.

I understand that George R. Gottlieb, M.D., P.C. will file only my Primary Insurance claims and I also understand that if I have any Secondary Insurance that I will be responsible for filing the claims myself.

I give my permission to George R. Gottlieb, M.D. to examine and treat me and/or my child.

_____ _____

Please print Parent and/or Guardian's name Signature Date

POLICY HOLDER INSURANCE INFORMATION

Name of Policy Holder: _____ Birth Date: _____ Relation: _____

Home Phone: _____ Business Phone: _____ Social Security No.: _____

Address of Insured: _____

Insurance Company: _____ Group No.: _____

Employer Name: _____ Address: _____