Kuldip S. Gill, MD PC
Grass Valley Extended Care, Inc.
280 Sierra College Dr. Ste. 205
Grass Valley, CA 95945
Phone: (530) 273-8452 Fax: (530) 477-5182

Patient Information Sheet

Please take a moment to review, making sure all fields are accurate and complete.

Please Print

Patient Last Name:	Patient First Name:	Middle Initial:	Date of Birth:
Mailing Address:	City:	State:	Zip Code:
Physical Address:	City:	State:	Zip Code:

Home Phone number with area code:

Ok to leave a message? ___Yes ___No ___Brief ___Extended

Cell Phone number with area code:

Ok to leave a message? ___Yes ___No ___Brief ___Extended

Work Phone Number with area code: Extension:

Ok to leave a message? ___Yes ___No ___Brief ___Extended

Social Security Number: Male Female

Marital Status: E-mail Address:

Emergency Contact:

Name: Relationship: Phone:

Name: Relationship: Phone:

Insurance Information:

Primary Insurance: ______________________________ ID #: ________________________

Secondary Insurance: ___________________________ ID #: ________________________

Prescription Insurance Information:

Prescription Insurance: __________________________ ID#: ________________________

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Pharmacy Information:

Pharmacy Name: Phone Number:

Additional Information:

Race (Circle as Appropriate): American Indian or Alaskan Native Asian Native Hawaiian

White African American or Black Other: ____________________

Ethnicity (Circle One): Hispanic or Latino Non-Hispanic or Latino Other: ____________________

Choose Not To Disclose

Birth Sex: _____Male _____ Female _____Unknown

Sexual Orientation: _____ Straight _____ Lesbian/Gay _____Bisexual _____ Do Not Know

_____ Choose Not To Disclose _____Something Else, Please Describe: ____________________

Gender Identity: ______ Male ______ Female ______ Other: Please Specify ____________________

______ Transgender: _____ Female-to-Male _____ Male-to-Female

______ Choose Not To Disclose

Language (Circle One): English Spanish Indian Russian Other: ____________________

Interpreter Needed? Yes No If yes, what is needed? ____________________

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PLEASE READ AND SIGN THE FOLLOWING

I understand I am financially responsible for all charges, whether or not covered by insurance. I understand Kuldip S. Gill, M.D./Grass Valley Extended Care, Inc may bill my insurance company for me if it is one with which is contracted. If not, I understand payment is due at the time of service. If I need to make special arrangements, I understand I will need to sign a budget agreement. I understand that any co-pay and or deductible will be due at the time of service based on information obtained from my insurance company. The information received by my insurance company is only an estimate and may change based on final review of the medical claim and the status of my insurance plan. If Dr. Gill or Grass Valley Extended Care, Inc is a non-participating provider with my insurance, a flat fee based on that day's visit, may be collected and applied to outstanding charges for courtesy billing of my medical charges.

Signature______________________________________ Date_____________

Insurance/Medicare Authorization

I request that payment of authorized insurance benefits includes Medicare benefits be made either to me or on my behalf to Kuldip S. Gill, M.D. or Grass Valley Extended Care, Inc for any services furnished to me by the physician/supplier. I authorize any holder of medical information about me to release any information necessary to pay the claim. If "Other Health Insurance" is indicated in item 9 in the HCFA 1500 form, or elsewhere on other approved claim forms of electronically submitted claims, my signature authorizes releasing of the information to the insurer of agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. I permit a copy of this authorization to be used in place of the original. This authorization is in force until it is either canceled or changed by me.

Signature___________________________________ Date_____________

STAFF ONLY

Verified By: ______________________ Date: ______________

Insurance Card: Scanned__________ Copied__________

Medical History Questionnaire

NAME: ______________________ **DATE:** ____/____/____

Please list ALL surgical procedures you have had in the past:

Surgery: ______________________ Date: ________ Surgery: ______________________ Date: ________
Surgery: ______________________ Date: ________ Surgery: ______________________ Date: ________
Surgery: ______________________ Date: ________ Surgery: ______________________ Date: ________

Have YOU had or are being treated for (check all that apply):

- ☐ Cancer
- ☐ Pacemaker
- ☐ Heart Attack
- ☐ Angina/Chest pain
- ☐ Congestive Heart Failure
- ☐ Stroke
- ☐ Blood clots
- ☐ Anemia
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Emphysema/COPD
- ☐ Asthma
- ☐ Bronchitis
- ☐ Tuberculosis
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Seizures/Epilepsy
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Lupus
- ☐ Hepatitis
- ☐ Sexually transmitted disease/HIV
- ☐ GI problems/bleeding
- ☐ Ulcers/Stomach problems
- ☐ Headaches
- ☐ Bone or Joint infection
- ☐ Eye problem/infection
- ☐ Chemical dependency (i.e. alcoholism/drugs)
- ☐ Other: ______________

Has anyone in your immediate FAMILY (parents, brothers, sisters) EVER been diagnosed with (check all that apply):

- ☐ Cancer
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Stroke
- ☐ Depression
- ☐ Tuberculosis
- ☐ Thyroid disease
- ☐ Blood clots

In the past 3 months have you had or are experiencing (check all that apply):

- ☐ Change in your health
- ☐ Dizziness/vertigo/balance problems
- ☐ Unexplained weight gain/loss
- ☐ Changes in bladder function
- ☐ Hearing/visual disturbances
- ☐ Fever/chills/sweats
- ☐ Difficulty swallowing
- ☐ Urinary tract infection
- ☐ Changes in appetite
- ☐ Upper respiratory infection
- ☐ Numbness/tingling
- ☐ Shortness of breath
- ☐ Nausea/vomiting
- ☐ Changes in bowel
- ☐ Difficulty sleeping

Please list any **medications** that you are currently taking (include pills, injections, and/or skin patches):

☐ Please see attached list

____
____
____

Allergies (Please list any medication(s) you are allergic to below):

____
____

____ ______________

Signature (THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE) DATE

Revised 02/01/2013

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CANCELLATION AND NO-SHOW POLICY

Patients are required to provide at least 24-hour advance if they are unable to attend their scheduled appointment.

CANCELLATIONS

If you do not cancel with at least 24-hour notice, you may be assessed a $50.00 fee, which must be paid before your next visit. If you are more than 15 minutes late for your appointment and we must reschedule your appointment, you may be charged the $50.00 cancellation fee.

NO SHOW

If you do not show up for your appointment you will be charged a $50.00 fee, which must be paid before your next visit.

Our providers and patient's time is valuable and appointments are in high demand. Cancelling an appointment within 24 hours allow us to fill appointments with patients who need and are eagerly awaiting medical attention.

Thank you,
Kuldip Gill M.D
Grass Valley Extended Care

By signing this form, I understand the above policies and procedures.

Signature: ______________________________ Date: ______________________

Print Patient Name: ________________________

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Acknowledgement Form

Notice of Privacy (NPP) For Health Information

Effective April 14th, 2003, the law requires Dr. Gill/Grass Valley Extended Care to inform our patients of the offices Notice of Privacy Practices for health information. This notice is available for you to read during regular business hours and is in our waiting room area. A copy of this notice is available to you upon request. By signing below, you acknowledge receipt of this notice as a patient, the patient's personal represented, the patient's authorized agent, or an individual involved in the patient's medical care. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

Print Patient Name:______________________________ **DOB:** ________________

Acknowledgement Signature:_________________________

Date:__________________

Print Name:_______________________

(If signed by someone other than patient)

Relationship to patient:________________________________

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name ______________________ **Date of Birth** ____________________

The above named person must indicate when this authorization is to expire:

- ☐ When information is received
- ☐ In one year
- ☐ In six months
- ☐ In three years
- ☐ On date ______________________

The person named above is or has been a patient of

Name of Person, Provider, or Facility: Kuldip S. Gill, MD PC
Grass Valley Extended Care, Inc.

Address: 280 Sierra College Dr. St. 205 Grass Valley, CA 95945

Phone: (530) 273-8452

Fax: (530)477-5182

The person named above hereby authorizes Dr. Kuldip Gill **to**

Name of Person, Provider, or Facility

- ☐ Request health information from
- ☐ Send health information to
- ☐ Discuss health information with
- ☐ Discuss health information with

The person named above authorizes information to be requested or released by representatives of

Name Of Person, Provider, Or Facility ______________________

Address ______________________

Phone ______________________

Fax ______________________

Scope

☐ All information regarding assessment, diagnosis, and treatment of patient's condition, concern, or disease (specify): ______________________

☐ All information regarding care received by patient between the dates of ____________ and ____________
Starting Date — Ending Date

☐ Other information (specify): ______________________

Authorization

____
Printed name of Patient or Authorized Representative

______________________ Signature of Patient or Authorized Representative — ________ Date — ______________________ Signature of witness — ________ Date

If not signed by the patient, indicate relationship of authorizing person to patient:

- ☐ Parent or guardian of minor child
- ☐ Guardian or conservator of conserved patient
- ☐ Beneficiary or personal Representative of a deceased individual

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Patient Name: Date of Birth:

To the patient: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure(s) to be used so that you may make the best decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician's Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I undertint that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient/Personal Representative ________________________ **Date**______________

Printed Name of Patient or Personal Representative________________________

Signature of Witness________________________ **Date**__________________

Printed name of Witness____________________

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Authorization for the release of health information to my family members.

I hereby authorize the following person(s) to receive medical information concerning my general medical care and treatment.

Name	Relationship	Address	Contact Number(s)

Patient Name: ______________________ Signature: ______________________

Date of Birth: ______________________ Date: ______________________