Mary Chen, MD Inc.

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PATIENT INFORMATION FORM

Today's Date

Referred by:

First Name

Middle Name / MI

Last Name

Date of Birth

Sex

Social Security Number

Marital Status

Patient Address Line 1

Patient Address Line 2

City

State *

Zip

Home Phone

Cell Phone

Employer Name

Work Phone

Email

IN CASE OF EMERGENCY CONTACT:

Emergency Contact Name

Emergency Contact Relationship to Patient

Emergency Contact Home Phone

Emergency Contact Cell Phone

INSURANCE:

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☐ Self-Pay

Primary Insurance Name

Primary Insurance Phone

Secondary Insurance Name

Secondary Insurance Phone

INTERPRETIVE SERVICES NEEDED:

Language *

Interpreter Services Required:

- ○ YES
- ○ NO

ADVANCE DIRECTIVES:

Do you have an Advance Directive? If yes, please provide a copy

- ☐ Yes
- ☐ No

Would you like information regarding Advance Directives? (It describes on what kind of treatment you would want depending on how sick you are.)

○ YES ○ NO

ASSIGNMENT OF BENEFITS:

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plan to the physician/facility on record. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all the charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

AUTHORIZATION OF MEDICAL RECORDS RELEASE:

I hereby authorize the physician to release any information required to process my chart.

AUTHORIZATION OF TREATMENT:

I hereby authorize the physician of record, and associates, to treat the above patient.

Patient's Signature

Date