Today's Date: ___________

Personal Information

Patient Name: ____
Last *First* *M.I.* *I prefer to be called*

Birth Date (MM/DD/YYYY): ____/____/______ Age: ________ ☐ Male ☐ Female

Patient is: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Minor

Social Security Number: ____–____–______ Driver's License # __________ Exp. Date: __________

Mailing Address: ____
Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

Home Phone: (   ) ______________ Work Phone: (   ) ______________

Cell Phone: (   ) ______________ E-mail: ____________@____________

Spouse/Partner Name: ____________________ Contact Phone: (   ) __________

Emergency Contact: ____________________ Relationship: __________

Home Phone: (   ) __________ Work Phone: (   ) __________ Cell Phone: (   ) __________

Who referred you to our office? ______________________________

Employer Information

Employer Name: ____________________ Occupation: ____________________

Address: ______________________________ How long? ______ years

Insurance Information

Primary Insurance Name: ____________________ Phone: (   ) __________

Mailing Address: ______________________________

Insured's Name: __________ Insured's DOB: __________ SS/ID # __________

Employer: __________ Group # __________ Relationship: __________

Secondary Insurance Name: ____________________ Phone: (   ) __________

Mailing Address: ______________________________

Insured's Name: __________ Insured's DOB: __________ SS/ID # __________

Employer: __________ Group # __________ Relationship: __________

Billing Information

Person ultimately responsible for this account: __________ Relationship: __________

Billing Address: ______________________________

Phone: (   ) ______________ E-mail: ____________@____________

Payment Method: ☐ Cash ☐ Check ☐ Credit Card

Keep CC # on file: ____________________ Exp. Date: __________

Terms and Conditions

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. ***I fully understand I am solely responsible for any balance not paid by my insurance company and that Dr. Wong is <u>not</u> a preferred provider.*** I authorize the staff to perform any necessary services during diagnosis and treatment. I also authorize the provider to release any information required to process my insurance claims.

I give my consent for the doctor and staff to use any photos he may take to be used for education or lecturing purposes.

I understand the office policy requires payment in full for services rendered at the time of the visit unless other arrangements have been made in advance. I am responsible to pay for any services over 90 days old and for legal fees, collection agency fees, interest charges and any other expenses incurred in collection of payment of my account.

Signature: ____________________ Date: __________ Relationship to Patient: __________