

PATIENT INFORMATION SHEET

Last Name: _____ Home Ph #: _____
First Name: _____ Work Ph #: _____
Street Address: _____ Mobile/Cell Ph#: _____
City: _____ May we leave phone messages? : yes / no
State: _____ Zip Code: _____ Date of Birth: _____
Drivers License #: _____ Social Security #: _____
Occupation: _____ Marital Status: married / single / other
Employer: _____ Sex: Male / Female
Work Address: _____ Emergency Contact: Name: _____
City: _____ Ph #: _____
State: _____ Zip Code: _____ Relationship: _____

INSURANCE INFORMATION:

Primary Insurance:

Secondary Insurance:

Insurance Co. Name: _____
Billing Address: _____
Group or Policy #: _____
Cert. Or Member #: _____
Name of Guarantor/
Parent/Insured: _____
Guarantor/Parent/
Insured DOB: _____
Guarantor/Parent/
Insured Social Security: _____
Relationship to you: _____

Who may we thank for referring you to this office? _____

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: **T. H. Choi, A Medical Corporation.***

This assignment will remain in effect until revoked in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, including but not limited to copayments and annual deductibles. I hereby authorize said assignee to release all information to secure the payment. I hereby consent to and authorize all treatment and medical services by the physician(s) and staff of this office, as they deem necessary. I authorize the release of any information regarding my history, treatment, findings, X-ray findings, and other clinical studies and diagnosis that this office deems necessary.

Signed : _____

Date: _____