PATIENT REGISTRATION

Please fill out this form entirely, without leaving any blank spaces. Once form is complete, please sign the bottom.

Please Print Clearly

Patient Name: ________________________________ **Today's Date:** ______________

DOB: ____/____/____ **Age:** _______ **Social Security Number (last 4 digits):** ______________

Please circle: Single / Married / Divorced / Widowed / Partnered

Please circle: Male / Female

Home Phone: (_______) _________-___________

Cell Phone: (_______) _________-___________

Work Phone: (_______) _________-___________

Email: ________________@_________.________

Mailing Address: ____

Street number and name – please remember apartment number (if needed)

____

City State Zip

If the patient is a minor, please indicate Parent's information for the questions below:

Employer: ______________________________ **Occupation:** ____________________

Spouse/Parent Name: ____________________ **Spouse/Parent Phone #:** (_____) _______-_________

Referring Doctor / Primary Care Physician: ______________________________

Emergency Contact (someone not living with you that we may contact – list below)

____

Name Relation Phone #

Primary Insurance Company: ________________________ **Effective Date:** ______________

Subscriber's Name: ______________________ **Subscriber:** Male or Female

Subscriber's SSN (last 4 digits): ____________________ **Subscriber's DOB:** ______________

Secondary Insurance Company: ________________________ **Effective Date:** ______________

Subscriber's Name: ______________________ **Subscriber:** Male or Female

Subscriber's SSN (last 4 digits): ____________________ **Subscriber's DOB:** ______________

Assignment of Benefits – Financial Agreement

I hereby give authorization for payment of insurance benefits to be made directly to EDWARD SUN, M.D., Inc. for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. In addition, I authorize the release of my records for peer review by physicians in order to ensure the highest quality of care is being provided to me.

Signature of Responsible Party: ______________________________ **Date:** __________