PATIENT INTAKE / INFORMATION SHEET

Last Name: ______________________________ **Home Ph #:** ______________________________

First Name: ______________________________ **Work Ph #:** ______________________________

Home Address: ______________________________ **Mobile/Cell Ph#:** ______________________________

City: ______________________________ **May we leave phone/email messages? :** yes / no

State: __________ **Zip Code:** __________ **Email:** ______________________________

Drivers License #: ______________________________ **Date of Birth:** ______________________________

Occupation: ______________________________ **Social Security #:** ______________________________

Employer: ______________________________ **Marital Status**: married / single / other **Sex**: Male / Female

Work Address: ______________________________ **Emergency Contact**: Name: ______________________________

City: ______________________________ Ph #: ______________________________

State: __________ Zip Code: __________ Relationship: ______________________________

Preferred pharmacy name and phone/fax no: (local) ______________________________

(mail-order) ______________________________

INSURANCE INFORMATION: **Primary Insurance:** **Secondary Insurance:**

(If insurance card copy available, can leave billing address blank)

	Primary Insurance	Secondary Insurance
Insurance 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:		

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. I understand that there may be a $25 charge if I miss an appointment and do not call 24 hr in advance to cancel.

Signed *:* ______________________________ ***Date****:* ______________________________