DR. TERESA YIN WONG, D.C.

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CONFIDENTIAL PATIENT REGISTRATION FORM

Please Let Us Know Who Referred You! ____

NAME: ____________________________________ HOME PHONE #: __________________________

ADDRESS:__________________________________CITY/STATE/ZIP: __________________________

SOCIAL SECURITY #: _______-________-________ DRIVER'S LICENSE #: ________________________

MARITAL STATUS: S / M / D / W SEX: Male / Female DATE OF BIRTH: _______/_______/______

EMPLOYER: ______________________________ OCCUPATION: ____________________________

ADDRESS: __________________________________CITY/STATE/ZIP: ________________________

WORK PHONE #: _________________________ MOBILE/PAGER #: ___________________________

EMAIL ADDRESS: ____

IN CASE OF EMERGENCY, PLEASE NOTIFY: _________________________ AT: __________________

IF YOU WERE INVOLVED IN AN ACCIDENT, PLEASE COMPLETE THE FOLLOWING:

IS THE INJURY A RESULT OF AN <u>AUTOMOBILE ACCIDENT</u>? If yes, please provide DATE: _____/_____/_____

DID THE INJURY OCCUR <u>AT WORK</u>? If yes, please provide DATE: ______/______/______TIME: ___________

IS THE INJURY DUTE TO ANOTHER TYPE OF ACCIDENT? If yes, PLEASE DESCRIBE: _________________

____

INSURANCE COMPANY: ________________________________ PLAN/CLAIM#: ____________________

BILLING ADDRESS: ____

ADJUSTER: ____________________________________ PHONE: ____________________________

BENEFITS: ____

<u>PLEASE NOTE</u>: This office will gladly prepare insurance forms and reports; however, we cannot render services on the assumption that our charges will be automatically paid by an insurance company. Therefore, basis of responsibility for payment is ultimately yours. I hereby authorize the release of any information necessary to process this claim and payment of medical benefits directly to Dr. Teresa Yin Wong, D.C. for services rendered.

PATIENT/GUARDIAN SIGNATURE: ___________________________________ **DATE:** _____/_____/_____