Dr. Chi-Shin Jason Chiu MD, DABA
1608 Lemoine Avenue, Suite 101
Fort Lee, NJ 07024
Tel: 201-592-7246 Fax: 201-540-9978

PATIENT INFORMATION

Last name:	First:	Middle:	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Sex: ❑ M ❑ F

Social Security no.:	Email:	Home Phone #: ( ) -	Cell Phone #: ( ) -
Street Address:	May we contact you via email/text message?	❑ Yes ❑ No	
City:	State:	ZIP Code:	
Occupation:	Employer:	Employer phone no.: ( )	

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital
❑ Family ❑ Friend ❑ Internet ❑ Attorney ❑ Other

Primary Doctor:		Phone #:	
Pharmacy Name:	City	Phone #:	

INSURANCE INFORMATION

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Subscriber ID #:	Co-payment (if applicable): $

Auto Insurance Company:	Claim Number:	Accident Date:	Policy no.:

Attorney Name:	Phone #:	Address:

IN CASE OF EMERGENCY

Name of friend or relative:	Relationship to patient:	Primary phone no.: ( )	Secondary phone no.: ( )

Disclosure: *In the event that any insurance payment is made directly to me, I understand that* ***it is my responsibility to forward any/all payments owed to the practice directly to The Painless Center****. I understand that The Painless Center is an out-of-network provider and that I may be responsible for any balance.*

X _____
Patient/Guadrian

X _____
Date