PATIENT REGISTRATION FORM

Name: ____
Last First Middle

Address: ____
Street City State Zip

Date of Birth: ___________________ Age: ________ Place of Birth: _______________________

Ethnicity: ___________________________________ Race: ________________________________

Home Phone: ( ) ______________________ Cell Phone: ( ) _________________________

Work Phone: ( ) _______________________ Social Security # __________________________

☐ OK to communicate by EMAIL to the following address: ____
for the purpose of anything related to your medical care.

Preferred method of contact: ( ) Home ( ) Cell ( ) Work ( ) Email

Marital Status: ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widow

Spouse's Name: ____

Name of your Employer: _______________________ Telephone: ( ) _____________________

Address: ____

Occupation: ____

Primary Language: ____

Referral Source: Doctor _________________________ Other Source: ________________________

Emergency Contact:

Name: ____________________________________ Telephone ( ) _________________________

Address: ____

Relationship: _____________________________

I hereby authorize my insurance company to pay Dr. Yung directly for all customary charges. I also authorize Dr. Yung to release any information requested by my insurance company or other agencies responsible for my healthcare bills that may be needed to properly process my claims. I understand that I am personally responsible for any co-pays, deductibles, co-insurances and/or any non-covered services. I further understand that if I do not have medical insurance, I will be responsible for the entire balance, and payment is expected at the time services are rendered. I have read, understand and agree with the above statement.

Signature of Patient / Responsible Party Date

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