Dr. Steve Y. Chung

PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Date ______________ Patient Name ______________________________ Patient # ____________
FIRST MI LAST
SS #/SIN ______________ ☐ Male ☐ Female Birthdate ______________ Home phone ____________
Address ______________________ City ______________ State/Prov. ______ Zip/P.C. ______
E-Mail ______________________________ Cell phone ______________________
Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Patient's or parent/guardian's employer ______________________ Work phone ____________
Business address ______________________ City ______________ State/Prov. ______ Zip/P.C. ______
Spouse or parent/guardian's name ______________ Employer ______________ Work phone ____________
If patient is a student, name of school/college ______________________ City ______________ State/Prov. ______
Whom may we thank for referring you? ______________________________
Person to contact in case of emergency ______________________ Phone ____________

Responsible Party

Name of person responsible for this account ______________________ Relationship to patient ____________
Address ______________________________ Home phone ____________
E-Mail ______________________________ Cell phone ____________
Driver's license # ______________ Birthdate ______________ Financial institution ____________
Employer ______________________________ Work phone ____________
Is this person currently a patient at our office? ☐ Yes ☐ No

Insurance Information

Name of insured ______________________________ Relationship to patient ____________
Birthdate ______________ SS #/SIN ______________ Date employed ____________
Name of employer ______________________ Work phone ______________________
Address of employer ______________ City ______________ State/Prov. ______ Zip/P.C. ______
Insurance company ______________ Group # ______________ Union or local # ____________
Ins. Co. address ______________ City ______________ State/Prov. ______ Zip/P.C. ______
How much is your deductible? ________ How much have you used? ________ Max. annual benefit? ________

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following:

Name of insured ______________________________ Relationship to patient ____________
Birthdate ______________ SS #/SIN ______________ Date employed ____________
Name of employer ______________________ Work phone ______________________
Address of employer ______________ City ______________ State/Prov. ______ Zip/P.C. ______
Insurance company ______________ Group # ______________ Union or local # ____________
Ins. Co. address ______________ City ______________ State/Prov. ______ Zip/P.C. ______
How much is your deductible? ________ How much have you used? ________ Max. annual benefit? ________

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X ______________________________ ______________________
Signature of patient or parent/guardian if minor Date

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