☐ Walter I. Choung, MD
2155 W Mustang Blvd
Beverly Hills, FL 34465
Phone (352) 746-5707

☐ Jeffry A. Dressander, M.D
520 SE 8th Ave
Crystal River, FL 34429
Phone (352) 564-2663

PATIENT INFORMATION

Patient Last Name ________ First Name ________ Middle/Maiden Name ________ Sex ________

Social Security Number ________ Birthdate ________ Age ________ Marital Status ________ Email ________

Street Address ________ City, State ________ Zip ________

Home Phone ________ **Cell Phone** ________ Employed By ________ Work Phone ________

Spouse's Name ________ Spouse's Social Security Number ________ Spouse's DOB ________ Cell Phone ________

INSURANCE INFORMATION

Primary Insurance ________ Phone ________ Secondary Insurance ________ Phone ________

Policy Holder ________ **DOB** ________ Policy Holder ________ **DOB** ________

Policy/ID Number ________ Policy/ID Number ________

*** **WERE YOU HURT AT WORK ?** ___ YES ___ NO***

RESPONSIBLE FOR ACCOUNT OF PATIENT UNDER 18

Father's Name ________ Father's Social Security Number ________

Father Employed By ________ Employers Address ________ Work Phone ________

Mother's Name ________ Mother's Social Security Number ________

Mother Employed By ________ Employers Address ________ Work Phone ________

Emergency contact: ____________________
Name ________ Work Phone ________ Cell Phone ________ Home Phone ________

Emergency contact: ____________________
(NOT living with you) Name ________ Work Phone ________ Cell Phone ________ Home Phone ________

REFERRAL INFORMATION

How did you hear about our practice?

___ Referred by Dr. ____________________ ___ Friend or Relative ___Radio ___ Newspaper

___ Magazine ___Yellow Pages ___ Google ___YELP ___ Facebook ___Other: ____________________

I have completed this form fully and completely, and certify that I am the patient, or duly authorized general agent of the patient, authorized to furnish the information requested. I understand that even though I may have some type pf insurance coverage, I am responsible for payment of service when they are rendered.

Date ____________________

Signature (Patient, Parent or Responsible Party) ____________________