WELCOME TO OUR OFFICE

HAUW T. HAN, M.D.
7760 Voice of America Park Dr. Ste. H
West Chester, Ohio 45069
513/755-8115

TODAY'S DATE ____________________

THANK YOU FOR CHOOSING OUR OFFICE.
In order to serve you properly, we will need the following information. All information will be strictly confidential.

First Name MI Last Name	Name to be called	Birthdate

Social Security Number	Sex M F	Martial Status S M W D	Age	Home Phone ( ) Cell Phone ( )

Residence Address City State Zip	Email

Name of Employer	Business Phone ( )

Employment Full Time Part Time Retired Unemployed	Occupation

Do you have medical insurance? Yes No	Insurance Company Name

Subscriber Name	Birthdate	Policy Number	Group Number

Name of Spouse	Employer	Social Security Number

Is there secondary insurance? Yes No	Insurance Company Name

Subscriber Name	Policy Number	Group Number

Person financially responsible for this account	Address

Name and phone number of nearest relative or friend not living with you

Primary Care Physician

AUTHORIZATION
I, the undersigned, have insurance with ______________________________ and assign directly to Dr. Han all surgical and/or medical benefits for services rendered. I understand that I am financially responsible for all charge whether or not paid by insuranoce. I hereby authorize the doctor to release all information necessary to secure payment of benefits. The above subscriber hereby authorizes their insurance company to issue indemnity checks to the above listed medical provider for services provided by them.

SIGNATURE ______________________________ DATE ____________________