Patient Demographic Form

Please PRINT

MRN Date

PATIENT INFORMATION

Last Name | First Name | Middle Initial | Nickname/AKA

Date of Birth | Social Security Number | Gender ☐ Male ☐ Female

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Life Partner ☐ Separated ☐ Widowed ☐ Other | Language other than English

Race (Optional) ☐ Black – Non Hispanic ☐ American Indian/ Alaskan Native ☐ Hispanic ☐ Asian/Pacific Islander ☐ White – Non Hispanic ☐ Other

Home Address | Apt # | City | State | Zip Code

Home Phone | Work Phone | Other Phone ☐ Cell ☐ Pager ☐ Fax

Email Address | Employment Status ☐ Active Duty Military ☐ Child ☐ Disabled ☐ Employed Full-Time ☐ Employed Part-Time ☐ Homemaker ☐ Not Employed ☐ Retired ☐ Self Employed ☐ Student Full-Time ☐ Student Part-Time ☐ Other

Employer | Employer Phone

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician | Referring Physician

How did you hear about us? ☐ Billboard ☐ Employer ☐ Family Member ☐ Friend ☐ Health Fair Event ☐ Insurance ☐ Magazine ☐ Mail ☐ News ☐ Physician ☐ Radio ☐ Television ☐ Website ☐ Yellow Pages ☐ Other

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient ☐ Self (If self, skip to Emergency / Next of Kin) ☐ Spouse ☐ Parent ☐ Other

Last Name | First Name | Middle Initial

Apt # City

Date of Birth | Social Security Number

Home Address | Apt # | City | State | Zip Code

Home Phone | Work Phone | Other Phone ☐ Cell ☐ Pager ☐ Fax

Employer | Employment Status ☐ Active Duty Military ☐ Child ☐ Disabled ☐ Employed Full-Time ☐ Employed Part-Time ☐ Homemaker ☐ Not Employed ☐ Retired ☐ Self Employed ☐ Student Full-Time ☐ Student Part-Time ☐ Other

Employer Phone

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name | First Name | Relationship to Patient

Address | Apt # | City | State | Zip Code

Home Phone | Work Phone | Other Phone ☐ Cell ☐ Pager ☐ Fax

OTHER CONTACT INFORMATION – NOT LIVING WITH PATIENT

Last Name | First Name | Relationship to Patient

Address | Apt # | City | State | Zip Code

Home Phone | Work Phone | Other Phone ☐ Cell ☐ Pager ☐ Fax

- If copies of insurance cards are not attached, please complete Patient Insurance Form

Leonard W. Liang, M.D.
Urological Surgery
Diplomate of the American Board of Urology

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Consent to receive and release medical information, records, and reports

I, _____, hereby give permission to and authorize the urologist, Leonard Liang, M.D., and his personnel to receive my medical information, records and reports and also to release my medical information, records and reports as is helpful in my care to other doctors or parties.

I understand that Dr. Liang has no control over how other doctors or agencies utilize or disseminate this information. I hereby release Dr. Liang and his personnel from all liability and claims related to disclosure of information or of professional opinions or recommendations as contained in the information released.

Date: _____

Patient Name: _____

Date of Birth: _____

Signature: _____