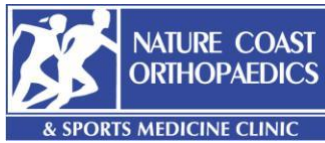


☐ Walter I. Choung, MD  
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Phone (352) 746-5707



## PATIENT DEMOGRAPHICS

|                              |                                 |                    |            |     |
|------------------------------|---------------------------------|--------------------|------------|-----|
| 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 of insurance coverage, I am responsible for payment of service when they are rendered.

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature** (Patient, Parent or Responsible Party)