TANGCHITNOB MD

MINIMALLY INVASIVE ROBOTIC SURGICAL GROUP FOR OBSTETRICS & GYNECOLOGY

PATIENT INTAKE FORM

Today's Date/Fecha: _____ / _____ / _____ DOB/Fecha de Nacimiento: _____ / _____ / _____

Name/Nombre: _____ Age/Edad: _____

Address: _____
Direccion Street/Calle City/Cuidad State Zip/Código

Home Phone/Teléfono: (_____) _____ - _____ Mobile: (_____) _____ - _____

Race/Raza: _____ Social Security No./Seguro Social: _____ - _____ - _____

INSURANCE INFORMATION:

Insurance Primary/Aseguranza Primaria: _____

Insurance Secondary/Aseguranza Secundaria: _____

Employer/Empleador: _____ Phone/Teléfono: (_____) _____ - _____

Business Address/Direccion de Tabajo: _____

Occupation/Ocupaccion: _____

Name of Spouse/Nombre de Esposo: _____

Emergency Contact: _____ Phone/Teléfono: (_____) _____ - _____

Referring Physician: _____ Phone/Teléfono: (_____) _____ - _____

AUTHORIZATION:

1. I hereby authorize payment directly to above physician of the surgical, medical benefits if any otherwise payable to me for his services as described on attached claim.
   ☐ YES ☐ NO
2. I realize that this may not represent a full payment for services rendered and I will be responsible for balance due that is not covered by my insurance.
   ☐ YES ☐ NO
3. I hereby authorize above named physician to release any information acquired the course of my examination or treatment.
   ☐ YES ☐ NO
4. I hereby authorize the above named physician and his staff to contact me via telephone regarding medical information.
   ☐ YES ☐ NO

Patient's Name: _____ Date: _____

Patient's Signature: _____

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