PATIENT INFORMATION

Vincent D. Ho, M.D.
8843 Valley Blvd.
Rosemead, CA 91770
Office: (626)287-8866
Fax: (626) 287-8861

Name: ___________________________ , __________________________________ **DOB:**_____/_____/______
(Last Name) (First Name) (Middle Initial) MM DD YY

Address: ____ City: _______________ State: ______ Zip: _________

Contact numbers: (_____)______-____________ (_____)______-__________ (_____)______-_____________
Home Cell Work

Race: _______________ **Language(s) Spoken:** ___________________________ Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Social Security #: ______-______-______

Emergency Contact: __________________________ ____________________ Phone:(____)______-________
(Last Name, First Name) (Relationship to the Patient)

Insurance Health Plan: ______________________________________ Policy/Subscriber ID _________________

How did you hear about us? ☐ **The Web** ☐ **Family** ☐ **Friends** ☐**Yelp** ☐**Other:** ________________________________

By signing below:

I certify the above demographic information is correct and I have read and understood the office policies included in this packet.

INSURANCE ASSIGNMENT:
I authorize **Vincent D. Ho, Inc** to bill my insurance carrier for all medical services rendered and if necessary release any medical or personal information required to process pending claims on my behalf. I understand that I am responsible for all non-covered services by my insurance.

ACKNOWLEDGEMENT OF RECEIPT: NOTICE OF PRIVACY PRACTICES
I have received and read the Notice of Privacy Practices and understand the complete description of the uses and disclosures of my health information. I understand that **Dr. Vincent D. Ho** has the right to change the content of the Notice of Privacy Practices and that I may obtain a current copy of the Notice of Privacy Practices.

ACKNOWLEDGEMENT OF NOTICE: NOTICE TO PATIENTS
I understand my physician, **Vincent D. Ho, MD** is licensed and regulated by the Medical Board of California.

____ ______________________
SIGNATURE OF PATIENT (OR GUARDIAN IF PATIENT IS A MINOR) DATE

THANK YOU AND WELCOME TO OUR PRACTICE!