Elizabeth Yang, M.D., P.A.

Patient Information Sheet 2007

Please print and complete all areas listed below.

Date:_____

PATIENT INFORMATION Date of Birth: _____ SSN: _____

Last Name:_____ First Name: _____ MI: _____ Gender □ Male □ Female

Home Address: _____Apt: _____City: _____State: _____ Zip:_____

Home Phone: _____ Work: _____ Marital Status: □ Married □ Single □ Divorced □ Widowed

Cell Phone: _____ Employer: _____

Work Address: _____

OTHER INFORMATION

Please list any other immediate family members who are patients of Dr. Yang.

First & Last Name of Family Members	Relation to Patient

PRIMARY INSURANCE INFORMATION

Policyholder (insured employee) Relation to patient: □ Self □ Spouse □ Parent □ Other_____

Last Name: _____ First Name: _____ Date of Birth: _____

Mailing Address: _____ Gender: □ Male □ Female

Home Phone: _____ Work: _____ SSN: _____

Employed by: _____ Cell: _____

Insurance Company: _____ ID#: _____

Insurance Address: _____ Group#: _____

_____ Insurance phone: _____

SECONDARY INSURANCE INFORMATION

Policyholder: _____ DOB: _____ Gender:□ M □ F relation to patient:_____

Insurance Company: _____ ID# _____

EMERGENCY CONTACT INFORMATION

Name:_____ Relationship to patient: _____ Phone: _____

► I authorize release of medical information to any insurance company required for processing of any/all medical claims for services provided to me or my dependent. I understand that the information to be released may include information pertaining to mental or psychiatric conditions and/or drug or alcohol abuse. I certify that the information I have provided herein is true and correct. A copy of this consent is as valid as the original and remains valid for six (6) months if patient is seen on the applicable basis or one (1) year for the patient seen annually, unless revoked by me in writing. I will be required to update my information every six (6) months as applicable.

► I understand payment is due at the time services are provided unless prior arrangements are made. I also understand that Elizabeth Yang, M.D., P.A. will file all charges to my insurance company only when they have a contact to do so. Services are provided to me or my dependent, not my insurance company, and I acknowledge that I am ultimately responsible for payment for said services.

► Payment may be made by cash, check or Visa or Master Card. If my checks is returned by the bank for any reason, I understand there will be a returned check fee of $25 incurred which is payable by me only in the form of cash, money order, or bankcard as previously listed.

► My signature acknowledges that I have read and understand the above and agree to payment term.

Signature (Patient or guardian):_____ Date: _____

Signature by witness: _____ Date: _____