

## Patient Information Sheet

Patient Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State & Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Employer: \_\_\_\_\_ Address: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Pharmacy Address/Phone: \_\_\_\_\_

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### Spouse Information

Spouse Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Spouse Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_

Spouse Cell Phone: \_\_\_\_\_ Spouse Work Phone: \_\_\_\_\_

### Emergency Contact Information

IN CASE OF EMERGENCY NOTIFY: (other than spouse) Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

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### Referral Information

Who May We Thank for Your Referral: \_\_\_\_\_

### Please Read the Following Authorization and Sign for Our File:

I hereby authorize payment directly to Dr. David W.I. Fong, M.D. of the medical/surgical benefits per my insurance company. I understand that I am financially responsible for the charges not covered by my insurance.

Signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_

I hereby authorize Dr. David W.I. Fong, M.D. to release to my insurance company any information required including the diagnosis and records in the course of my examination and treatment.

Signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_