

**PATIENT INFORMATION FORM** \_\_\_\_\_ (today's date)

Thank you for coming to Dr. Chen's office for medical consultation. In order to serve you properly, the following **CONFIDENTIAL** information will be needed. **PLEASE PRINT** all information.

1. \_\_\_\_\_ (Last name), \_\_\_\_\_ (first name) \_\_\_\_\_ (M.I)
2. \_\_\_\_\_ (name you preferred to be called)      3. \_\_\_\_\_ (DOB)
4. \_\_\_\_\_ (home address) \_\_\_\_\_ (city, state, zip)
5. \_\_\_\_\_ (social security #)      6. \_\_\_\_\_ (driver's license #)
7. (\_\_\_\_\_) \_\_\_\_\_ (home phone #)      8. (\_\_\_\_\_) \_\_\_\_\_ (business phone #)
9. (\_\_\_\_\_) \_\_\_\_\_ (cell phone #)      10. (\_\_\_\_\_) \_\_\_\_\_ (fax #, if available)
11. \_\_\_\_\_ (name/address of spouse or partner)  
\_\_\_\_\_ (phone #, include cell and/or pager)
12. \_\_\_\_\_ (emergency contact, in addition to spouse/partner)  
\_\_\_\_\_ (phone #, include cell and/or pager)
13. If the patient is under the age of 18, who may authorize treatment?  
\_\_\_\_\_ (name/phone #) \_\_\_\_\_ (relationship)
14. Whom shall we thank for referring you? \_\_\_\_\_

**RELEASE OF INFORMATION & FINANCIAL RESPONSIBILITY**

I authorize Yun-Ching Chen, M.D. to furnish my insurance companies all information that may be requested now or in the future. I understand that I am financially responsible for all services provided or ordered by Dr. Chen.

\_\_\_\_\_ patient's signature      \_\_\_\_\_ guarantor's signature, if minor      \_\_\_\_\_ date