Patient Insurance Information

Welcome to our office. So that we may assist you in filling your health insurance forms, please provide us with the information requested below.

Name _____ Today's Date_____
Last First M.I
Mailing Address _____ Age_____

_____
State City Zip Code

Home Phone (__)_____Work Phone (__)_____Cell Phone (__)_____

E-mail Address _____

Date of Birth _____ /____/ ____ SS # _____ Marital Status_____ Sex _____

Employer_____ Retired _____ Full Time Student _____

Spouse / Parent Name: _____ Employer_____ Work # _____

Person to Notify in case of emergency _____ Phone # _____

Primary Care Doctor _____ Phone # _____

Name of Insurance Plan _____

May we leave a message on your home answering machine ? Y N
May we leave a message for you at work to call us ? Y N

How did you hear about our practice ? _____

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(Note : We do not bill absent parents, the adults presenting the minor for care is the responsible party.)

Policy Holder (If different from patient or responsible party) _____

Policy Holder's Date of Birth ____/ _____/ ____ SS # _____

Employer Of Policy Holder _____

Patient's Relationship to Policy Holder _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I have insurance coverage with _____ and assign directly to Dr. Linda Liu all insurance benefit, if any otherwise payable to me for services rendered. I understand that I am Financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature
Date