PATIENT REGISTRATION FORM
Chia Chia Cheng

Patient	(Please Print)	Today's Date
❑ New ❑ Existing		/ /

PATIENT INFORMATION

Last Name	First Name	M

Home Address	Mailing Address

City	State	Zip Code	City	State	Zip

Gender	Date Of Birth	Age	Social Security Number	Marital Status (Circle One)
❑ F ❑ M	/ /			Single Married Divorced Separated

Home Phone	Cell Phone	Email Address	Work Phone
( )	( )		( )

May we leave voicemail messages?	At Your Home:	❑ Yes ❑ No	At Your Work:	❑ Yes

IN CASE OF EMERGENCY

Emergency Contact	Home Phone	Work Phone	Ext.	Relationship
	( )	( )		

EMPLOYMENT INFORMATION

Employment Status

❑ Full Time ❑ Part Time ❑ Not Employed ❑ Active Military ❑ Self Employed ❑ Retired ❑ Student ❑ Other:

Occupation	Employer	Employer P
		( )

Employer Address	City	State	Zip

PHYSICIAN INFORMATION

Referring Physician	Primary Care Physician

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Primary Insurance Company	Group Number	Insurance Id. Number

Patient's Relationship To Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other:

Subscriber Information

Last Name	First Name	Gender		Date Of Birth	Employ
		❑ F	❑ M	/ /	

(Continued On Other Side)

INSURANCE INFORMATION

Second Insurance Company	Group Number	Insurance Id. Number	Co-Pay

Patient's Relationship To Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other:

Subscriber Information

Last Name	First Name	Gender		Date Of Birth	Employer
		❑ F	❑ M	/ /	

Third Insurance Company	Group Number	Insurance Id. Number	Co-Pay

Patient's Relationship To Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other:

Subscriber Information

Last Name	First Name	Gender		Date Of Birth	Employer
		❑ F	❑ M	/ /	

ACCIDENT INFORMATION

Work Injury?		Date Of Work Injury	Auto Accident Injury?		Date Of Auto Accident Injury
❑ Yes	❑ No	/ /	❑ Yes	❑ No	/ /

Responsible Insurer	Employer or Policyholder	Policy Number	Claim Number

FINANCIAL RESPONSIBILITY
(If other than patient)

Last Name	First Name	Middle

Mailing Address	Home Phone	Work Phone
	( )	( )

City	State	Zip Code	Relationship To Patient
			❑ Parent ❑ Guardian ❑ Other:

FINANCIAL AGREEMENT — SIGNATURE REQUIRED

I understand that I am financially responsible for all charges rendered by Chia Chia Cheng whether or not they are covered by insurance. I hereby give lifetime authorization for payment of insurance benefits directly to Chia Chia Cheng accounts. I acknowledge that I am solely responsible in securing the necessary **REFERRALS** from my **PRIMARY CARE PHYSICIAN**. In the event of default I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

I have read the above FINANCIAL AGREEMENT and understand it.

_____ _____

Signature **Date**

_____ _____

Parent/Guardian Signature – If patient is a minor **Date**