Patient Registration Form

Wenfu Chen M.D.

Today's Date: _____/ _____/ _____

(PLEASE PRINT)

First Name: _______________________ M.I. ______ Last Name:________________________

Mailing Address: ____

(Parent's Name if patient is a minor) ____

City: __________________________ State: _________________ Zip Code: ______________

Date of Birth (MM/DD/YYYY; required for insurance claims) : _____/ _____/ _____

Sex (circle one): Male Female

Home Phone Number (including area code): ___________________________________

Work Phone Number (including area code): ____________________________________

Social Security Number: _____________ - ____________ - _____________

Marital Status (circle one): Single Married Divorced Widow/Widower

Employed (circle one): Yes No

Employer's Name (required): ____

Referred by: Dr. ________________________________

Insurance Plan Information:
Please list of all of your insurance policies (including Medicare and Medicaid)

1. Primary:_________________________

Card Holder's Name: __________________

Social Security Number:

_________ - _________ - _________

Date of Birth (required): ____ / ____ / ____

Relationship to Patient:

____

Employer's Name:

____

2. Secondary: _____________________

Card Holder's Name: _____________________

Social Security Number:

_________ - _________ -_________

Date of Birth (required): ____ / ____ / ____

Relationship to Patient:

____

Employer's Name:

____

I consent to treatment necessary for the care of the above-named patient.
I authorize the release of any medical information necessary to process my insurance claims, and to the referring family physicians.
I allow fax transmittal of my medical records if necessary.
I understand that I am financially responsible for all charges whether or not paid by insurance. Any copay, coinsurance, deductible or non-covered services are due and payable at the time of service.
I understand that it is my responsibility to obtain a written referral from my family physician if I am required to do so by my insurance policy, and to know which provider is affiliated with my insurance company's network.
I authorize payment of medical and/or surgical benefits to Dr. Wenfu Chen.

Signature: ____

Date: __________________________