Terry C. Lin D.O., Inc.

PATIENTS PERSONAL INFORMATION

Marital Status: □ Single □ Married □ Divorced □ Widowed Sex: □Male □Female

Name: _____ _____ _____
Last Name First Name Middle Initial

Street Address: _____ D.O.B: ____/____/____
Month Day Year

City: _____ State: _____ Zip: _____

Home Phone: (___) _____ Work Phone (___) _____ Cell Phone (___) _____

Email Address: _____ Social Security #: _____ - _____ - _____

Race: □ American Indian or Alaska Native □ Asian □ African American □ Native Hawaiian or Other Pacific Islander
□ White □ Decline to Answer

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Decline to Answer Language Preference: _____

Employer: _____ □ Part Time □ Full Time

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____

Spouse Name: _____ Spouse Social Security#: _____ - _____ - _____
Last First Initial

Spouse's Employer: _____ Spouse Work Phone: (___) _____

Address: _____ City: _____ State: _____ Zip: _____

PATIENT'S INSURANCE INFORMATION

Please give receptionist insurance card

Primary Insurance Company: _____

Name of Insured: _____ D.O.B: ____/____/____ Relationship to Insured: _____

Insurance ID #: _____ Group #: _____

Secondary Insurance Company: _____

Name of Insured: _____ D.O.B: ____/____/____ Relationship to Insured: _____

Insurance ID#: _____ Group #: _____

REFERRAL INFORMATION

Referred by: _____ Phone#: (_____) _____

Primary Care Physician: _____ Phone #: (_____) _____

Other Physician: _____ Phone #: (_____) _____

COMMUNICATIONS

Preferred method of receiving confidential info: □Email □Mail □Home Ph □Cell Ph □Patient Portal

Emergency Contact: _____ Phone # : (_____) _____

For all office appointments we require a 24 hour notice and for all procedures we require a 72 hour notice of cancellations. If the cancellation policy is not kept or you are considered to be a "NO SHOW" the day of the procedure or office appointment, a broken appointment fee may incur.

Signature: _____ **Date:** _____

I directly assign all medical/surgical benefits to the doctor and understand that I am financially responsible for all charges whether or not paid by my insurance company. I authorize Dr. Terry Lin to release all information necessary to secure payment of benefits. I understand the doctor's office may be unable to determine if a valid authorization for services is required or has been obtained, or if the physician is currently a participating provider. I further agree that a photocopy of this original shall be as valid as the original

Signature _____ **Date:** _____

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