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:** ____________________