Patient Registration Information

Please PRINT and complete ALL sections below. Thank you.

Co-pay $: ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25
☐ 30 ☐ 35 ☐ 40 ☐ 45 ☐ 50 ☐ Other

Is your condition a result of a work injury? ☐ YES ☐ NO

An auto accident? ☐ YES ☐ NO
Date of injury ____________ Place (State) ____________

PATIENT'S PERSONAL INFORMATION:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed   Sex: ☐ M ☐ F

Last Name: ____________ First Name: ____________ Middle Initial: ____________

Address: ____________

City, State: ____________ Zip Code: ____________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Birthdate: ____________ Social Security: ____________

E-Mail: ____________

PATIENT'S / RESPONSIBLE PARTY INFORMATION:

Insured's Last Name: ____________ First Name: ____________

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Birthdate: ____________ Social Security: ____________

PATIENT'S INSURANCE INFORMATION:

PRIMARY Insurance Name: ____________ Insurance ID: ____________ Group #: ____________

SECONDARY* Insurance: ____________ Insurance ID: ____________ Group #: ____________

*Without supplemental insurance, patients are financially responsible (please read "Financial Policy" guidelines).

PATIENT'S REFERRAL INFORMATION:

Referred By: ____________ Request a copy of medical records? ☐ YES ☐ NO

Name(s) of other physicians who care for you: ____________

PATIENT'S EMERGENCY CONTACT:

Name: ____________ Relationship: ☐ Spouse ☐ Parent ☐ Friend ☐ Other

Address: ____________

City, State: ____________ Zip Code: ____________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Assignment of Benefits - Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to William J. Tsai, M.D., Inc. and any assisting physicians, for services rendered. I understand I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorneys' fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as this original.

Patient's Signature: ____________ Today's Date: ____________

Method of Payment: ☐ cash ☐ check (A $30 penalty fee will be charged on all returned checks).