Doctors: ☐ CHARLES OH, M.D.

Date: _____

PATIENT INFORMATION

Marital Status: ○ M ○ S ○ W ○ D

NAME _____ (LAST) _____ (FIRST) _____ (MI) SEX _____ DATE OF BIRTH _____ AGE _____

ADDRESS _____ (STREET #) _____ (APT #) _____ (CITY) _____ (STATE) _____ (ZIP)

HOME PHONE _____ PAGER OR CELL PHONE _____

SOCIAL SECURITY # _____ OCCUPATION: _____

REFERRED BY: _____ WORK PHONE: _____

FINANCIALLY RESPONSIBLE PARTY

OCCUPATION: _____ SUBSCRIBER'S NAME _____ (LAST) _____ (FIRST) _____ (MI)

EMPLOYER _____ (COMPANY NAME) ADDRESS _____ (STREET #) _____ (APT #)

_____ (COMPANY ADDRESS) _____ (CITY) _____ (STATE) _____ (CITY) _____ (STATE) _____ (ZIP)

WORK PHONE _____ SOCIAL SECURITY # _____

SPOUSE

Name: _____ EMPLOYER _____

_____ (WORK ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP) _____ (PHONE)

RELATIVE OR FRIEND

Name: _____ RELATIONSHIP TO PATIENT: _____

_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP) _____ (PHONE)

INSURANCE INFORMATION

PRIMARY

INS. CO.: _____ PHONE#: _____

ADDRESS: _____

SUBSCRIBER NAME: _____ RELATIONSHIP TO PATIENT _____

SUBSCRIBER #: _____ GROUP #: _____

SECONDARY

INS. CO.: _____ PHONE#: _____

ADDRESS: _____

SUBSCRIBER NAME: _____ RELATIONSHIP TO PATIENT _____

SUBSCRIBER #: _____ GROUP #: _____

AUTHORIZATION

I HEREBY AUTHORIZE AND DIRECT MY INSURANCE CARRIER TO PAY DIRECTLY TO THE PHYSICIAN NAMED ABOVE ANY BENEFITS DUE ME UNDER MY INSURANCE PLAN. I AGREE TO PAY THE BALANCE OF EXPENSES NOT PAID UNDER THIS PLAN. I AUTHORIZE THE PHYSICIAN TO RELEASE TO MY INSURANCE CARRIER ANY MEDICAL INFORMATION NECCESSARY TO PROCESS THIS CLAIM.

POINT OF SERVICE PATIENTS: I UNDERSTAND THAT I MAY BE RESPONSIBLE FOR AN ADDITIONAL CO-PAY IF I HAVE GONE "OUT OF NETWORK" (ACCORDING TO INDIVIDUAL PLAN GUIDELINES).

AUTHORIZED SIGNATURE: X _____

I acknowledge that I have been provided the HIPAA Notice of Privacy Practices