

**Welcome To Our Office**

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First Middle  
Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_ Ext \_\_\_\_\_ Cell( ) \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex: M F Single Married Widowed Separated Divorced

**Insurance Information**

Name of Insurance Company: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone #: ( ) \_\_\_\_\_  
Insured's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
Group Number: \_\_\_\_\_ Policy ID Number: \_\_\_\_\_ Relationship to Patient: Self Child Spouse Other

*[Secondary Insurance]*

Name of Insurance Company: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
Group Number: \_\_\_\_\_ Policy ID Number: \_\_\_\_\_ Relationship to Patient: Self Child Spouse Other  
Relationship to Patient: Self Child Spouse Other

Referred by: Dr.: \_\_\_\_\_ Yellow Pages: Friend Insurance Newspaper Other \_\_\_\_\_  
In case of emergency, contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

*[Injuries and Accidents]*

Were you injured at work? Yes No In an auto accident? Yes No  
Date of Injury: \_\_\_\_\_ Is an attorney involved? Yes No  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Did you report the accident to your employer? Yes No

Responsible Party: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: ( ) \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  
Occupation: \_\_\_\_\_ SSN: \_\_\_\_\_  
Employer: \_\_\_\_\_ Years There: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Office visits co-pays or deductibles are payable on the day you are seen. Please remember you are responsible for all fees, regardless of insurance coverage. All HMO's, IPA's and EPO's require prior authorization for each office visit. This is your responsibility. If we do not receive the authorization, payment is due at the time of service.

Method of Payment: Cash Check Mastercard or Visa  
Signature of Patient or Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

**Acknowledgement of Review of Notice of Privacy Practices**

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative \_\_\_\_\_ Date: \_\_\_\_\_

Name of Patient or Personal Representative \_\_\_\_\_ Description of Personal Representative's Authority \_\_\_\_\_

Laurence Chu, M.D., P.A.