Bay Area Oriental Family Practice, P.A.

PATIENT INFORMATION & QUESTIONNAIRE FORM

Please complete entire form, date and sign (Please Print)

Referred By_____ First Visit Date:_____

Patient Name_____
Last First Middle

Date of Birth:_____/_____/_____Age:_____SSN#_____
Marital Status_____ Spouse Name_____
Address_____
Street Apt # City State Zip
Home Phone (____)_____ Work Phone(____)_____ Sex: M_ F_
Employed By_____ Occupation_____
E-mail:_____ Cell Phone_____

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation):

_____
_____

Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name_____ Phone Number_____
Name_____ Phone Number_____

Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

_____
_____

Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL": YES_____ NO_____

By checking this box you agree to receive recurring text messages from Bay Area Oriental Family Practice, Reply STOP to Opt out. Reply HELP for help. Message frequency varies. Message and data rates may apply. Carriers are not liable for delayed or undelivered messages. ☐

Insurance Information**********
Insurance Company_____ Address_____ Phone_____

Insured Name_____ ID#_____
Insured Birth Date_____ Policy#_____Group#_____

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES TO ME, INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF POSSIBLE INSURANCE BENEFITS.

_____ _____
PATIENT/GUARDIAN SIGNATURE **DATE**