Chi C. Shum M.D.
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Patient Information Form

Name: _____ **Sex**: __M __F **Birth Date**: _____
Marital Status: __ single __ married __ divorced __ widowed **SS#**: _____
Home Add: _____Apt#____ City_____ State_____Zip_____
Home Phone # : _____ **Email Address: _____**
Name of Employer: _____ **Occupation**: _____
Work Address: _____
Work Phone # : _____
Emergency Contact: _____ **Phone #** : _____
Relationship to Patient: _____ **Pharmacy phone number: _____**

Insurance Information

Insurance Co.: _____ **Policy #**: _____
Subscriber's Name: _____ **Group #**: _____
Relationship to Subscriber: _____ **Birth Date**: _____ **SS#**: _____

Other Insurance: _____ **Policy #**: _____
Subscriber's Name: _____ **Group #**: _____
Relationship to Subscriber: _____ **Birth Date**: _____ **SS#**: _____

I have completed this form and certify that I am the patient or duly authorized agent of the patient, authorized to furnish the information requested. I understand that even though I may have some type of insurance coverage, I am responsible for payment and that payment is due on the date service is received. I authorize the release of medical history, information, or records concerning my diagnosis and treatment by Chi C. Shum M.D. and/or Angelina V. Lauchangco M.D. to substantiate or explain insurance claims filed, and I authorize payment directly to this Physician/Provider and permit a copy of this authorization to be used in place of the original. This authorization will remain in effect until revoked by me in writing. If I have Medicaid/Medicare coverage, I request that payment of authorized Medicaid/Medicare benefits be made on my behalf to Chi C. Shum M.D. and/or Angelina V. Lauchangco M.D. for any services rendered to me by that Physician/Provider. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (Section 1128B of the Social Security Act and 31 U. S. C. 3801-3812 provides penalties for withholding this information). I authorize any holder of information about me to release as agent to Chi C. Shum M.D. and/or Angelina V. Lauchangco M.D. any information needed to determine those benefits or the benefits payable for related services.

_____ _____

Signature of Patient or Authorized Person **Date**