## Chi C. Shum M.D. 210 E 47<sup>th</sup> Street Suite 1A New York, NY 10017 (212)308-4894 Fax (646)585-9194

**Patient Information Form** 

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 is have some type of insurance coverage, I am responsible for payment and that payment is the date service is received. I authorize the release of medical history, information, or reconcerning my diagnosis and treatment by Chi C. Shum M.D. to substantiate or explain insurance claims filed, and I authorize payment directly to this Physician/Provider and pecopy of this authorization to be used in place of the original. This authorization will remeffect until revoked by me in writing. If I have Medicaid/Medicare coverage, I request the payment of authorized Medicaid/Medicare benefits be made on my behalf to Chi C. Shum 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 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 release as agent to Chi C. Shum M.D. any information needed to determine those benefit	Name:		Sex: _	_MF Bir	rth Date	e:	
Name of Employer: Occupation:  Work Address: 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 have some type of insurance coverage, I am responsible for payment and that payment is the date service is received. I authorize the release of medical history, information, or reconcerning my diagnosis and treatment by Chi C. Shum M.D. to substantiate or explain insurance claims filed, and I authorize payment directly to this Physician/Provider and pecopy of this authorization to be used in place of the original. This authorization will remeffect until revoked by me in writing. If I have Medicaid/Medicare coverage, I request the payment of authorized Medicaid/Medicare benefits be made on my behalf to Chi C. Shur for any services rendered to me by that Physician/Provider. I understand it is mandatory to 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 release as agent to Chi C. Shum M.D. any information needed to determine those benefit	Marital Status: sing	le married _	divorced	widowed	SS#:		
Name of Employer: Occupation:  Work Address: 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 have some type of insurance coverage, I am responsible for payment and that payment is the date service is received. I authorize the release of medical history, information, or reconcerning my diagnosis and treatment by Chi C. Shum M.D. to substantiate or explain insurance claims filed, and I authorize payment directly to this Physician/Provider and pecopy of this authorization to be used in place of the original. This authorization will remeffect until revoked by me in writing. If I have Medicaid/Medicare coverage, I request the payment of authorized Medicaid/Medicare benefits be made on my behalf to Chi C. Shur for any services rendered to me by that Physician/Provider. I understand it is mandatory to 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 release as agent to Chi C. Shum M.D. any information needed to determine those benefit	Home Add:		Apt#	City		State	Zip
Work Address:  Work Phone #:  Emergency Contact:  Relationship to Patient:  Pharmacy phone number:  Insurance Information  Insurance Co.:  Policy #:  Subscriber's Name:  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 have some type of insurance coverage, I am responsible for payment and that payment is the date service is received. I authorize the release of medical history, information, or reconcerning my diagnosis and treatment by Chi C. Shum M.D. to substantiate or explain insurance claims filed, and I authorize payment directly to this Physician/Provider and pecopy of this authorization to be used in place of the original. This authorization will remeffect until revoked by me in writing. If I have Medicaid/Medicare coverage, I request the payment of authorized Medicaid/Medicare benefits be made on my behalf to Chi C. Shur for any services rendered to me by that Physician/Provider. I understand it is mandatory to 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 release as agent to Chi C. Shum M.D. any information needed to determine those benefit	Home Phone # :		Email A	Address:			
Work Address: Work Phone #: Emergency Contact: 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 have some type of insurance coverage, I am responsible for payment and that payment is the date service is received. I authorize the release of medical history, information, or reconcerning my diagnosis and treatment by Chi C. Shum M.D. to substantiate or explain insurance claims filed, and I authorize payment directly to this Physician/Provider and pecopy of this authorization to be used in place of the original. This authorization will remeffect until revoked by me in writing. If I have Medicaid/Medicare coverage, I request the payment of authorized Medicaid/Medicare benefits be made on my behalf to Chi C. Shur 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 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 release as agent to Chi C. Shum M.D. any information needed to determine those benefit	Name of Employer:			Occupat	ion:		
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