Scott Liang, M.D., Inc.

4153 E Live Oak Ave, Arcadia, CA 91006, Tel 626-628-0808, Fax 626-628-0809, www.drscottliang.com

REGISTRATION FORM (PAGE 1)

(Please Print)

Welcome to our medical clinic! It is our pleasure to serve you!	Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (circle one) ☐ Single / ☐ Mar / ☐ Div / ☐ Sep / ☐ Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ☐ M ☐ F

Street address:	Social Security no.:	Home phone no.:

City, State	Zip code:	Mobile Phone: E-mail address:

Occupation:	Employer: Name of Spouse:	Work Phone: Spouse Mobile:

Referred by (please check any that apply and fill in info:	☐ Family, Name_____	☐ Insurance Plan	☐ Hospital

☐ Zocdoc	☐ Yelp	☐ Google	☐ Dr._____	☐ Other_____	☐ Friend, Name:_____

Driver's License No:	Name of other family members seen here:

INSURANCE INFORMATION

Must be filled out by patient or representative AND please give all insurance cards and IDs to the receptionist.

Person responsible for bill:	Birth date:	Address (if different):	Home phone: Mobile phone:

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	**Subscriber ID:**	Work phone:

Please indicate primary insurance	☐ Medicare	☐ Blue Cross	☐ Blue Shield	☐ Health Net	☐ Allied HMO

☐ United Healthcare	☐ Aetna	☐ Tricare	☐ Optum HMO	☐ Other _____

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:		Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Subscriber ID:	Group no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone:	Mobile phone:

The above information is true to the best of my knowledge.

Patient Name _____

Patient/Guardian signature _____ Date _____

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REGISTRATION FORM (PAGE 2)

INSURANCE:

- I authorize that my claims be sent to the insurance I provided, and my insurance benefits be paid directly to the physician. Initial _____

- I understand that I am financially responsible for any non covered service, balance, deductible and co-pay. Initial _____

- I also authorize Scott Liang, M.D., Inc. or insurance company to release any information required to process my claims. We will bill the patient provided insurance, however if denied, it will be the patient's responsibility to resolve. Initial_____

- The practice will attempt to verify active coverage for the date of service; however it is NO GUARANTEE that the insurance will cover that service. Initial_____

- It is the patient's responsibility to find out the actual coverage and will be responsible should the service not be covered. Initial_____

- **NEW PATIENTS ONLY: First visits will be billed as new patients, NOT AS PHYSICALS. Physicals may only be scheduled for established patients. New Patient Initial _____**

Please sign here that the Insurance Policy is acknowledged and accepted.

Name _____Date:_____

PATIENT BALANCES OR INSURANCE NON COVERED SERVICES:

- Any balance that falls over 30 days may be subject to a $30 late fee. Please contact our office immediately so that payment options can be worked out and late fee avoided. Initial_____

- Should the patient fall delinquent past 60 days, any and all means will be utilized to collect, up to and including late fees and forwarding to a COLLECTION AGENCY. Initial_____

Please sign here that the Patient Balance policy is acknowledged and accepted.

Print Name of Responsible Party_____

Patient/Responsible Party signature *Date*

_____ _____

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REGISTRATION FORM (PAGE 3)

Name: _____ Date:_____

CONFIDENTIAL PATIENT RECORDS

Personal Medical History (Please list all medical diagnoses)		

Personal Surgical History (Please list all prior surgery and date of surgery)		

Family History (Please list known conditions of family members)
Mother:
Father:
Siblings:
Maternal Grandparents:
Paternal Grandparents:
Other:

Social History	
Smoking? ☐ Packs/day: # years:	Alcohol? ☐ Drinks/week: Concern?
Illicit drug use? (Please list any)	Exercise:

Health Maintenance Screening (Please list test date and known results)		
Cholesterol	Mammogram	
Sigmoid/Colonoscopy	Dexascan	
PSA	Pap smear	
Flu shot	Tetanus/TDAP	Pneumonia Vaccine

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REGISTRATION FORM (PAGE 4)

Name: _____ Date:_____

Medications I am allergic to:	
Pharmacy Name:	Phone Number:
Pharmacy Location:	

Prescription Medications I Take		
Medication Name	Dosage	How Often
1.)		
2.)		
3.)		
4.)		
5.)		
6.)		
7.)		
8.)		
9.)		
10.)		

Over the counter Medications I take		
Medication or Supplement Name	Dosage	How Often
1.)		
2.)		
3.)		
4.)		
5.)		
6.)		
7.)		