

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:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date: / /	Age: Sex: <input type="checkbox"/> M <input type="checkbox"/> 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:			<input type="checkbox"/> Family, Name_____		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Zocdoc	<input type="checkbox"/> Yelp	<input type="checkbox"/> Google	<input type="checkbox"/> Dr._____	<input type="checkbox"/> Other_____	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Occupation:	Employer:	Subscriber ID:			Work phone: ()	
Please indicate primary insurance		<input type="checkbox"/> Medicare	<input type="checkbox"/> Blue Cross	<input type="checkbox"/> Blue Shield	<input type="checkbox"/> Health Net	<input type="checkbox"/> Allied HMO
<input type="checkbox"/> United Healthcare	<input type="checkbox"/> Aetna	<input type="checkbox"/> Tricare	<input type="checkbox"/> Optum HMO		<input type="checkbox"/> Other _____	
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:	Co-payment: \$	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Name of secondary insurance (if applicable):		Subscriber's name:		Subscriber ID:	Group no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> 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 _____		

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 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_____

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*

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 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

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 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.)		