PATIENT REGISTRATION

Name: _____ **Date:** _____

Birth Date: _____ **Age:** _____ **Sex (Circle):** **M** **F**

Social Security #: _____

Address: _____ **Apt:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **E-mail:** _____

Employer: _____ **Occupation:** _____

Race (Circle): **Asian, Black (African American), Hispanic, Indian, Declined White, More than 1 race, Other:** _____

Language (Circle): **English, Other**

_____

Ethnicity (Circle): **Hispanic or Latino, Not Hispanic, Declined**

Marital Status (Circle): **Single Married Divorced Widow/Widower**

Spouse: _____ **Spouse's Work #**_____

Person to Notify in Emergency: _____ **Phone:** _____

Parent's Name (If patient is a minor): _____

Primary Care Physician: _____

Referred by: _____

I have read and accept Dr. Jennifer Loh's Privacy Policy, which insures that my medical records will be released only to my Insurer, and authorize the release of medical information to them in order to determine benefits. I request the payment of authorized insurance benefits be made on my behalf to Jennifer Loh, M.D. for any services provided. I understand that my records will not be released to anyone else without my written authority.

Lifetime Medicare Signature: _____ Date: _____

Primary/Supplementary Insurance Signature: _____ Date: _____