

TERESA YIN, D.C.

JAMIE HE, D.C.

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CONFIDENTIAL PATIENT REGISTRATION FORM

Please Let Us Know Who Referred You! _____

NAME: _____ HOME PHONE #: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

SOCIAL SECURITY #: _____ - _____ - _____ DRIVER'S LICENSE #: _____

MARITAL STATUS: S / M / D / W SEX: Male / Female DATE OF BIRTH: ____/____/____

EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

WORK PHONE #: _____ MOBILE/PAGER #: _____

EMAIL ADDRESS: _____

IN CASE OF EMERGENCY, PLEASE NOTIFY: _____ AT: _____

IF YOU WERE INVOLVED IN AN ACCIDENT, PLEASE COMPLETE THE FOLLOWING:

IS THE INJURY A RESULT OF AN AUTOMOBILE ACCIDENT? If yes, please provide DATE: ____/____/____

DID THE INJURY OCCUR AT WORK? If yes, please provide DATE: ____/____/____ TIME: _____

IS THE INJURY DUE TO ANOTHER TYPE OF ACCIDENT? If yes, PLEASE DESCRIBE: _____

INSURANCE COMPANY: _____ PLAN/CLAIM#: _____

BILLING ADDRESS: _____

ADJUSTER: _____ PHONE: _____

BENEFITS: _____



PLEASE NOTE: This office will gladly prepare insurance forms and reports; however, we cannot render services on the assumption that our charges will be automatically paid by an insurance company. Therefore, basis of responsibility for payment is ultimately yours. I hereby authorize the release of any information necessary to process this claim and payment of medical benefits directly to Teresa Yin, D.C. (Teresa Yin Wong Chiropractic Corporation) for services rendered.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: ____/____/____