GARY C. LEE, PH. D., M. D. INC.

(Please Print)

Today's date: _____

PATIENT INFORMATION

First Name: _____ Last Name: _____ M.I.: ___

Street Address: _____ City: _____ State: ___ Zip: _____

Social Security #: _____-____-_____ Home Phone: ____-____-_____ New or Return Patient

Date of Birth: ____/____/_____ Sex: ___Male ___Female Marital Status: S/M/D/W

PARENT OR RESPONSIBILITY PARTY (if patient is a minor)

Name: _____Address: _____Phone: ____-____-_____

Employee By: _____Occupation: _____

Address: _____Work Phone:____-____-____

Name of Spouse: _____Spouse Employed By: _____

Social Security #: _____-____-_____ Occupation: _____

In case of emergency, who should be notified?

Full Name: _____ Address: _____ Phone: ____-____-____

INSURANCE INFORMATION (Please present insurance card at time of check in)

Primary Insurance Name: _____	Secondary Insurance Name: _____
Ins. Address: _____	Ins. Address: _____
Name of Insured: _____	Name of Insured: _____
Insured's ID: _____	Insured's ID: _____
Group # (if applicable) _____	Group # (if applicable) _____
Relationship of patient to the insured: _____	Relationship of patient to the insured: _____

Please Circle Payment Type: Medicare EPO/PPO HMO CASH CHECK Credit Card

Pharmacy of choice: _____Phone: ____-____-_____

Physician referred: _____ Phone: ____-____-_____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed as necessary to process insurance claims, insurance application and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature: _____ Date: ____/____/_____

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform y ou of the financial payment policies of this office. Payment and co-payment is collected at the time of the service. We accept payment in the form of cash, check or credit card. There will be a $35 service fee for all returned check. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature: _____ Date: ____/____/_____

Do we have your permission to:

Leave a message on your answering machine at home? ____Yes ____No

Discuss your medical condition with any member of your household? ____Yes ____No If so, whom _____

Patient or Responsible Party Signature: _____ Date: ____/____/_____