Date: _____/_____/_____ New Update

PATIENT

Patient Last Name	First Name	Middle Initial
Birthday	Sex M F	Social Security#
Martial Status Married Single Other	Occupation	Race/Ethnicity
Street Address	City State	Zip
Home Telephone Preferred #	Message/Cell Phone Preferred #	Email Address
Employer Name	Employer Telephone	Employer Address

MAIN INSURANCE CARD HOLDER

? Same as above.

Patient Last Name	First Name	Middle Initial
Birthday	Sex M F	Social Security#
Martial Status Married Single Other	Occupation	Race/Ethnicity
Street Address	City (Ciudad) State	Zip
Home Telephone	Message/Cell Phone	Email Address
Employer Name	Work Telephone	Employer Address

EMERGENCY CONTACT

Last Name	First Name	Relationship
Street Address	City State	Zip Code
Home Telephone	Message/Cell Phone	Employer Telephone

Medicare Patient:
I request that payment of authorized benefits be made either to me or on my behalf to Karin C. Li, MD or her Medical Corporation for any services rendered to me by the physician or his/her associate. I authorize any holders of medical information about me to release to the health care financing administration and its agents any information needed to determine benefits or the benefits payable for related services. I hereby authorize Medicare to furnish to the doctor any information regarding my Medicare claims under Title XVIII of the Social Security Act. A Copy of this Signature is as valid as the original.
Commercial Ins Patient:
I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to the doctor, or group indicated on the claim. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.
Name___________________________________ Signature____________________________________ Date_____/_____/_____
Claim # (Medicare)_______________________________