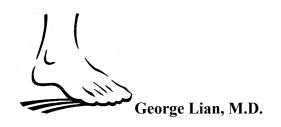
NEW PATIENT INFORMATION



Name:			Birthdate:		Age:	
(Last)	(First)	(M.I.)				
Social Security #:			Sex:	M	F	
Mailing Address:						
(Street	or P.O. Box)		(City)		(Zip)	
Residence Address:(Street			(City)		// 7 :->	
(Street)		(City)		(Zip)	
Home Phone #:	Work Phone #		Cell Phone #:		:	
Employer	Occupation					
Spouse's Name	Spouse Birthdate Spouse Employer					
Emergency Contact Name &	Phone #:					
If Patient is a Minor: Father Father's Employer			Mother Mother's Employer			
Father's Work Phone Father's Social Security Father's Birthdate			Mother's Work Phone Mother's Social Security Mother's Birthdate			
What is the Reason for your	Visit?:					
Date of Injury, Onset:		Right? _	Left?	_ What H	appened ?	
Primary Physician:	Referred By:					
Your Ethnicity: Hispanic	ed Language: English Other: y: Hispanic Non-His					
Your email Address:						
Would you like to be enrolled	to receive copi		onal Health Record to be		on-line? Yes No	

I understand that I am financially responsible for all charges whether or not they are paid by medical insurance. I will also be responsible for any costs of collection or attorneys fees in the event that they are necessary. I hereby authorize the release of any and all information necessary to secure payments from my medical insurance carrier. I also authorize my insurance carrier by my signature below to pay any medical benefits directly to Dr. George Lian. As with all information you provide this will remain private.

Signed: _____

_____ Date: _____