NEW PATIENT INFORMATION

George Lian, M.D.

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) (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 _____ Mother _____
Father's Employer_____ Mother's Employer _____
Father's Work Phone _____ Mother's Work Phone _____
Father's Social Security _____ Mother's Social Security _____
Father's Birthdate _____ Mother's Birthdate _____

What is the Reason for your Visit?: _____

Date of Injury, Onset: _____ Right? _____ Left? _____ What Happened ? _____

_____

Primary Physician: _____ Referred By: _____

Your Preferred Language: English _____ Other: _____
Your Ethnicity: Hispanic _____ Non-Hispanic _____ Other _____
Your Race: _____

Your email Address: _____

Would you like to be enrolled to receive copies of a Personal Health Record to be accessed 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:** _____
Patient or Responsible Party