Y. HOWARD PUNG, M.D., F.A.C.A.A.I.

Diplomate, American Board of Allergy, Asthma and Immunology

PATIENT REGISTRATION

Referring Source:_____ and/or **Primary Physician:**_____

I. PERSONAL INFORMATION: **Cell:**(_____) _____ -_____
Name (*Last, First*):_____ **Home:**(_____) _____ -_____
Address:_____ **Apt:**_____
City:_____ **State:**_____ **Zip:**_____ **Date of Birth:** _____/_____/_____
Sex: M / F **Martial Status:** S / M / W / D **Social Security #:** _____-_____-_____

EMPLOYED BY:_____
Business Address:_____ **Suite:**_____
City:_____ **State:**_____ **Zip:**_____ **Work:**(_____)_____ -_____ **ext.**_____

IN CASE OF EMERGENCY CONTACT:
Name:_____ **Relationship:**_____
Cell:(_____) _____ -_____ **Home:**(_____) _____ -_____ **Work:**(_____)_____ -_____

II. RESPONSIBLE PARTY: (*Who is financially responsible for the account?*)
Name: **[ ]Self**_____ **Relationship to Patient:**_____
Address: **[ ]Same as Patient's**_____
City:_____ **State:**_____ **Zip:**_____ **Cell/Home:**(_____) _____ -_____
Date of Birth: _____/_____/_____ **Social Security #:** _____-_____-_____
Employer:_____ **Work:**(_____)_____ -_____ **ext.**_____

III. INSURANCE INFORMATION:

A. PRIMARY INSURANCE:

Name of Insured:_____ **Insured's Birth Date:**_____/_____/_____
Relationship to Patient:_____ **Insured's SSN:**_____-_____-_____
Insured's Employer:_____ **Insurance Company:**_____
ID #:_____ **Group #:**_____ **Plan #:**_____

B. SECONDARY INSURANCE:

Name of Insured:_____ **Insured's Birth Date:**_____/_____/_____
Relationship to Patient:_____ **Insured's SSN:**_____-_____-_____
Insured's Employer:_____ **Insurance Company:**_____
ID #:_____ **Group #:**_____ **Plan #:**_____

PATIENT'S AUTHORIZATION

I hereby authorize Dr. Y. Howard Pung to give me and/or my dependents reasonable and proper medical care by today's standards and to apply for benefits on behalf of myself and/or dependents for all services rendered. I certify that the information I have reported herein is correct and authorize the doctor to release all necessary information, including medical information, to secure the payment of benefits**. I hereby assign directly to Dr. Y. Howard Pung all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.** I authorize the use of this signature on all my insurance submissions. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or above names carriers at any time in writing.
***** I also acknowledge that I received and read a copy of the HIPPA Privacy Act.

_____ _____/_____/_____
Authorized Signature of Subscriber/Beneficiary or Guardian **Date**