DR. THONG VAN TRUONG, DPM, INC
PATIENT REGISTRATION

PATIENT NAME:_____

MARITAL STATUS: S / M / D / W SEX: M F

DATE OF BIRTH:_____/_____/_____ EMAIL:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____PHONE: (____)_____

SOCIAL SECURITY NO:_____

PATIENTS EMPLOYER:_____
ADDRESS:_____WORK PHONE: (____)_____

SPOUSES NAME:_____SSN:_____
SPOUSES EMPLOYER:_____
ADDRESS:_____WORK PHONE: (____)_____

IF PATIENT IS A MINOR:

FATHERS NAME:_____ MOTHERS NAME:_____
ADDRESS:_____ ADDRESS:_____
SSN:_____DOB:_____/_____/_____ SSN:_____DOB:_____/_____/_____
EMPLOYER:_____ EMPLOYER:_____
ADDRESS:_____ ADDRESS:_____
PHONE: HM_____WK_____ PHONE: HM_____WK_____

HOW DID YOU HEAR ABOUT OUR OFFICE?_____

FAMILY PHYSICIAN:_____

REFERRED BY:_____

INSURANCE INFORMATION:

PRIMARY INSURANCE:_____INSURED NAME:_____
SECONDARY INSURANCE:_____INSURED NAME:_____

Medical release: I authorize examination and treatment for myself or a dependent family member. I understand that I am responsible for any bills incurred by myself for family members for medical treatment, regardless of insurance coverage or third party liability. I hereby authorize assignment of benefits to be paid directly to Dr. Thong Truong. I authorize release of information to the insurance companies listed above. All professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage. You will be required to pay for services when rendered unless other arrangements have been made in advance with the practice manager. If billed, payment is due within thirty (30) days. Thong V. Truong, DPM reserves the right to charge a late fee for bills not paid within thirty (30) days.

SIGNATURE:_____DATE:_____