HOWARD TUNG, M.D.

Please Complete All Entries

PATIENT INFORMATION

Patient Name (Last-First-Middle)	Sex M F	Date of Birth	Age	Social Security Number
Address (Street-City-State-Zip)		Marital Status ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated		
		Home Phone Number ( )		
		Cell Phone Number ( )		

Name of Employer	Occupation	Employer's Address (Street-City-State-Zip)
Name of Spouse (Last-First-Middle)		Spouse's Cell Phone Number ( )

Date of Injury	Injury Occurred (mark one) ☐On Job ☐Traffic Accident ☐Other	Do you have an Attorney? ☐Yes ☐No
Attorney Information		Phone Number ( )
Attorney Address (Street-City-State-Zip)		
Nearest Friend / Relative Not Living With You		Phone Number ( )
In Case of Emergency, Notify		Emergency Phone Number ( )
Primary Physician		Primary Physician's Phone Number ( )
Referring Source?		Phone Number ( )
Who is Financially Responsible for Payments?		I Prefer to Pay With ☐Cash ☐Check ☐Insurance ☐Lien

INSURANCE INFORMATION - (Provide Insurance Card)

Primary Insurance Name	Address (City-State-Zip)		Phone Number ( )
Name of Insured	Relationship	I.D. No.	Group No.
Primary Insurance Name	Address (City-State-Zip)		Phone Number ( )
Name of Insured	Relationship	I.D. No.	Group No.

I understand and agree that I am ultimately responsible for payment. I certify this information is true and correct to the best of my knowledge.

APPLICATION FOR MEDICAL TREATMENT

I hereby authorize Howard Tung, M.D. to administer any treatment as may be deemed necessary and advisable in the diagnosis and treatment of the above named Patient.

I hereby authorize Howard Tung, M.D. to furnish information concerning this illness and I hereby assign him all payments for medical services rendered. A copy of this authorization is as valid as the original. I understand that I am financially responsible for the charges not covered by this authorization.

SIGNED _____ RELATIONSHIP_____ DATE _____