Rodney Z. Wong, M.D., Inc.
REGISTRATION FORM
(Please print clearly)

☐ *Mountain View Office* ☐ *Morgan Hill Office*

PATIENT DATA

Today's date: ______________________

Last name: ________________________________ **First name**: __________________________ **Middle:** ________ ☐Male ☐Female

Birth date: ________________________ **Age**: __________ **Social Security Number**: ______________________________________

Street address: ____ **City:** ___________________ **State**: _______ **Zip:** ______________

Home Number: __________________________ **Cell:** ____________________________ I preferred to be contacted at ☐Home ☐Cell

Email: ____ (We do not share email addresses with third party companies)

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Decline to Specify **Language:** _______________________________

Race: ☐American Indian/Alaska native ☐Asian ☐Black/African American ☐Native Hawaiian/Pacific Islander ☐White ☐Decline to specify.

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Decline to Specify.

Employer:____ **Occupation:** ______________________________________

Address: ____ **City:** ______________________ **State**: _______ **Zip:** ______________

Employer Phone number:____________________________________ **Supervisor**:__________________________ **Ext #:** _________

Other family members seen here: ______________________________ **Who referred you to our office?**:______________________

Insurance Subscriber Information

** **Subscriber/Guarantor**: ____ **Birth Date**: _______________________

Your relationship to Patient: ______________________________ Is subscriber a patient here? ☐Yes ☐No ______________________

** **If you have provided our office with your insurance card/s, you do not need to fill out the insurance information below.**

Insurance: _________________________________ ID#: ______________________________ Group# ___________________________

** **If the subscriber's address if different from the patient, please provide that address below.**

Subscriber/Guarantor's Address: ____ City: ______________________________

State: ________ Zip: _______________ Phone Number: ____

Next of Kin

Name of friend or relative: ____ Relationship to patient: ______________________

Phone #: ____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for my balance. I also authorize Rodney Z. Wong, M.D., Inc., or insurance company to release any information required to process my claims.

Patient /Guardian Signature: ____ Date: ___________________________