HANH N. HOANG, MD
Obstetrics & Gynecology

PATIENT REGISTRATION

PATIENT INFORMATION			
First Name	MI	Last Name	Date of birth
Other name(s) used	Email	Marital status	
Address	City	State	Zip
Home phone	Cell phone	Work phone	
Occupation	Employer	Primary care provider	

RESPONSIBLE PARTY (GUARANTOR)			
First Name	MI	Last Name	Date of birth
Address	City	State	Zip
Home phone	Cell phone	Work phone	
Occupation	Employer	Relationship to patient	
Primary Insurance	Member ID		
Secondary Insurance (if applicable)	Member ID		

EMERGENCY CONTACT (For minor child, this section may be used for other parent)			
Name of local friend or relative	Relationship to patient	Home phone	Cell phone

The information provided above is accurate to the best of my knowledge. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage. I agree, in the event of non-payment, to bear the cost of collection and reasonable legal fees. I hereby authorize Dr. Hanh Hoang to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. I fully understand this agreement and consent will remain valid until revoked by me in writing.

Signature of Patient/Responsible Party

Date

Name of Patient/Responsible Party (please print)

Relationship to Patient