Willie Yu, MD

Physical Medicine & Pain Management

20 YEARS LOCAL PATIENT CARE

6550 Mercantile Dr. E
Suite 104
Frederick, MD 21703
Ph: 301.668.0888
Fax: 301.668.0999

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Name: _____

Street Address: _____ City: _____ State: _____ ZIP: _____

Date of Birth: _____ Age: _____ Gender: F / M Marital Status: _____

Race: (circle one) Caucasian African American Asian Other

Cell: _____ Home: _____ Work: _____

Preferred Contact: (circle one) Cell Home Work E-mail address: _____

SSN: _____ Occupation: _____

Employer's Name: _____

Employer's Address: _____

Person to Call in Case of Emergency: _____

Relationship: _____ Phone: _____

Who Refers You to Our Office? _____

Primary Care Physician: _____
Name Address Phone

Preferred Pharmacy: _____

INSURANCE INFORMATION

Primary Insurance: _____

Patient Insurance ID: _____ Group number:_____

Relationship to Policy Holder: (circle one) Self Spouse Child Other

Policy Holder's Name, if Different than Patient: _____

Policy Holder's DOB: _____ Policy Holder's SSN: _____

Policy Holder's Employer: _____

Secondary Insurance: _____

Patient Insurance ID: _____ Group number:_____

Relationship to Policy Holder: (circle one) Self Spouse Child Other

Policy Holder's Name, if Different than Patient: _____

Policy Holder's DOB: _____ Policy Holder's SSN: _____

Policy Holder's Employer: _____

PATIENT AUTHORIZATION

1. **ASSIGNMENT OF INSURANCE BENEFIT: I hereby authorize direct payment of medical benefits to Dr. Willie Yu for services rendered by him in person. I understand that I am financially responsible for any balance not covered by my insurance.**
2. **AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Dr. Willie Yu to release any medical, or incidental information that may be necessary for either medical care or in processing applications for financial benefits.**
3. **AUTHORIZATION TO CHECK PAST MEDICATION HISTORY: I hereby authorize Dr. Willie Yu to check any past medication history.**
4. **HIPPA: I acknowledge I have received and read a copy of Dr.Willie Yu's office Notice of Patient Privacy Practices.**

Patient/Representative Signature: _____ Date: _____