



PATIENT INFORMATION

17400 Irvine Blvd, Ste H • Tustin, CA 92780 • Tel: 714.832.7212 • Fax: 714.832.0554

Today's Date: _____

PATIENT INFORMATION

Patient's Name (Last, First): _____ Date of Birth: _____ Sex: M F
Name you prefer to be called (Mr. Smith, Mrs. Jones, Bob, Peggy, nickname, etc): _____
Patient's Address: _____ City, State, Zip: _____
Home Phone Number: _____ Cell Phone Number: _____
Social Security #: _____ Driver License #: _____
Employed by: _____ Occupation: _____
Business Address: _____ City, State, Zip: _____
Business Phone Number: _____

How did you hear about our practice/ whom may we thank for referring you? _____
(If referred by another doctor, as a service to you, we will automatically send a report to your physician or physicians about your foot problem and outtreatment plans)

SPOUSE/ PARENT/ GUARDIAN INFORMATION

Name (Last, First): _____ Date of Birth: _____
Address: _____ City, State, Zip: _____
Home Phone Number: _____ Cell Phone Number: _____
Social Security #: _____ Drive/s License #: _____
Employed by: _____ Occupation: _____
Business Address: _____ City, State, Zip: _____
Business Phone Number: _____

EMERGENCY CONTACT

Phone #: _____
Address: _____ City, State, Zip: _____

INSURANCE INFORMATION

Primary Carrier Name: _____ Primary Carrier Phone #: _____
Member's Name (if not patient): _____ Relationship: _____
Secondary Carrier Name: _____ Secondary Carrier Phone #: _____
Member's Name (if not patient) Relationship: _____

I hereby authorize Dr. Charles Baik and his associates to examine, photograph, administer treatment, and to perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot/ankle problem. I assign the right to payment for all medical benefits directly to Dr. Charles Baik in consideration for medical services and supplies provided pursuant to my health insurance plan. I give consent to Dr. Baik to release medical information to other healthcare providers for the purpose of treatment, when necessary for my care. I give consent to Dr. Baik to send medical information, as necessary to my insurance plan. I agree that a photo copy of this form may be used in lieu of the original. If my insurance does not accept liability for the treatment performed, or if I have failed to follow the identification and treatment authorization procedures for my insurance plan, I shall be liable for payment. I certify the above information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature: _____ Date: _____
If Legal Representative, Relationship to Patient: _____