

Brian C. Su, M.D.
1151 El Centro St. Suite A
South Pasadena, CA 91030

Account #: _____

Patient's Personal Information

Patient's Last Name: _____ First
Name: _____ M.I. _____
Street Address: _____
City: _____ State: _____
Zip Code: _____
Race: _____ Sex: _____
Employer: _____
Occupation: _____
Employer's Address: _____
Referring Doctor: _____

Home Phone #: () _____
Cell Phone #: () _____
Work Phone #: () _____
Date of Birth: _____
Social Sec. #: _____
Driver's Lic. #: _____
Single ___ Married ___ Divorced ___
Phone #: () _____

Information of the Patient's Spouse or Legal Guardian

Last Name: _____
Date of Birth: _____
Street Address: _____
Cell Phone #: _____
Race: _____
Employer: _____
Employer's Address: _____

First Name: _____
Social Sec. #: _____
Work Phone #: _____
Occupation: _____

Patient's Insurance Information

Primary Insurance Company: _____
Subscriber #: _____ Group #: _____
Claims Mailing Address: _____
Phone #: () _____

Emergency Contact

Name: _____
Home Phone #: () _____

Relationship: _____
Cell Phone #: _____

I (The patient, Legal Guardian or Subscriber) am an eligible member of _____ and a guaranty of the service. Signature of responsible party below acknowledges full financial responsibility for service rendered to the patient. If the patient is determined to be "not eligible" or if service rendered is determined to be a non-covered benefit under the plan of provisions, I hereby authorize payment directly to the physician. I understand that I am financially responsible to the physician for the charges not covered by this agreement. The physician's office may disclose any patient's record to any person or corporation which is or may be liable under a contract to the office, or to the patient for all or part of the charge, including but not limited to the office of medical service co., insurance co., or workman's comp.

There will be charges on all bad checks and copying of medical records

Patient's Signature: _____ Date: _____