DR. ANGELINA LAUCHANGCO
210 East 47th Street Ste 1-A
New York, NY 10017

PATIENT INFORMATION FORM

Name: _____Age_____ Date of Birth: _____
Address: _____Apt#_____ City_____
State_____ Zip_____ Social Security#_____
Home Phone #: _____Cell Phone_____
Name of Employer: _____ Occupation: _____
Work Address: _____
Work Phone #: _____ **Email:** _____

Sex: M____ F____ Marital Status: __ single __ married __ divorced __ widowed

EMERGENCY Contact: _____ Phone #: _____
Relationship to Patient: _____
Spouse/Partner's Name_____
Spouse/Partner's Employer_____ Work Phone_____
Referred by_____

Insurance Information

Insurance Co.: _____ Policy #: _____
Subscriber's Name: _____Subscriber's DOB _____
Relationship to Subscriber: _____ Insurance Group _____
Other Insurance: _____ Policy #: _____
Subscriber's Name: _____Subscriber's DOB _____
Relationship to Subscriber: _____ Insurance Group _____

I have completed this form and certify that I am the patient or duly authorized agent of the patient, authorized to furnish the information requested. I understand that even though I may have some type of insurance coverage, I am responsible for payment and that payment is due on the date service is received. I authorize the release of medical history, information, or records concerning my diagnosis and treatment by Angelina V. Lauchangco M.D. to substantiate or explain insurance claims filed, and I authorize payment directly to this Physician/Provider and permit a copy of this authorization to be used in place of the original. This authorization will remain in effect until revoked by me in writing. If I have Medicaid/Medicare coverage, I request that payment of authorized Medicaid/Medicare benefits be made on my behalf to Chi C. Shum M.D. and/or Angelina V. Lauchangco M.D. for any services rendered to me by that Physician/Provider. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (Section 1128B of the Social Security Act and 31 U. S. C. 3801-3812 provides penalties for withholding this information). I authorize any holder of information about me to release as agent to Angelina V. Lauchangco M.D. any information needed to determine those benefits or the benefits payable for related services.

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Signature of Patient or Authorized Person Date