Ted Shen M.D., Inc.
960 East Green Street
Suite 101
Pasadena, CA 91106
Phone (626) 737-6200

51 N. 5th Ave
Suite 200
Arcadia, CA 91006
Fax (626) 737-6202

Patient Information Date: _____

Patient Name: _____
LAST FIRST MIDDLE

Address: _____
STREET & APT # CITY STATE ZIP

Home Ph#: _____ Mobile Ph#: _____ Other Ph#: _____

Any restrictions for contacting you? ❑ No ❑ Yes: _____

May we leave detailed messages on your voicemail or answering machine? ❑ No ❑ Yes

Email: _____ Driver's License: _____

Birthdate: _____ / _____ / _____ Age: _____ SSN: _____ Sex: ❑ Male ❑ Female

Race: _____ Primary Language_____

Marital Status: ❑ Single ❑ Married to: _____ ❑ Other: _____

Referred by: _____

Employer/School: _____ Occupation: _____

Work Ph #: _____ Ext: _____ Is it ok to call you at work? ❑ Yes ❑ No

Emergency Contact: _____ Relationship: _____

Home #: _____ Mobile #: _____ Other #: _____

Primary Health Insurance: _____

Policy #: _____ Group #: _____ Ins. SS#: _____

Name of Insured: _____ DOB: _____ Relation: _____

Secondary Health Insurance: _____

Policy #: _____ Group #: _____ Ins. SS#: _____

Name of Insured: _____ DOB: _____ Relation: _____

Medicare ID#: _____

I hereby authorize direct payment of surgical/medical benefits to Ted Shen M.D., Inc. for services rendered by Dr. Shen or persons under their supervision. I understand that I am financially responsible for any balance not covered by my insurance.

I hereby authorize Ted Shen M.D., Inc. to release any medical/incidental information that may be necessary for medical care or in the processing of applications for financial benefit.

I certify that all the information given by me in applying for payment is correct. I authorize release of all records upon request. I request that payment of authorized benefits be made on my behalf.

I understand that office visit charges are payable on the day service is rendered. I authorize Ted Shen M.D., Inc. to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. If my balance is not paid within 120 days of service date, it will be sent to collections and a 15% fee will be added to the total.

Signature: _____ Date: _____

Name (if Signed By Parent/Guardian): _____