

Welcome to the Office of DR. ANNA FONG

PATIENT INFORMATION

Name _____
 First Middle Last

Address _____
 Street City State/Zip

Phone: Home _____ Work _____ Cell/Pager _____

Birthdate _____ Sex (M/F) _____ Social Security Number _____

Employer/School _____ Type of Work _____

Spouse's Name _____

Names and Ages of Children _____

Referred by _____

BILLING INFORMATION

Responsible Person _____

Address _____
 Street City State/ Zip

Phone: Home _____ Work _____ Cell/pager _____

Birthdate _____ Social Security Number _____

PLEASE CHECK YOUR PREFERRED METHOD OF PAYMENT

Cash _____ Check _____ Visa/Master Card _____ Driver's License _____

PLEASE CHECK IF ONE APPLIES TO YOU

VSP _____ MESC _____ FHP _____ MEDI-CAL _____ MEDICARE _____ PRIVATE _____

FINANCIAL AGREEMENT

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment.

Signature _____ Date _____
