SUNNY LO DO

612 W DUARTE RD #601 ARCADIA, CA 91007

Phone: (818) 659-5887 Fax: 701-409-2589

PATIENT DEMOGRAPHIC FORM

PATIENT INFORMATION

_________________ _________________ _________ (______)- ______-_______

Last Name First Name Mid. Initial Cell/Home #:

Email : ________________________

____

Home Address

Date Of Birth :_____/_____/______

☐ Male ☐ Single

☐ Female ☐ Married

☐ Widow

☐ Other

____

City State Zip Code

______________________________ (_____)-_____-_____

Employer Phone #

Social Security # _____-_____-_____

____

Business Address

Driver License/ID # __________________

____

City State Zip Code

EMERGENCY CONTACT INFORMATION

_______________________ _____________________ (______)- ______-______

Last Name First Name Cell / Home Phone #

Relationship to patient ______________________________

PHARMACY INFORMATION

Name of Pharmacy: ___________________ Pharmacy Phone # ______-_______-________

Address: ____

City: _________________________ Zip Code:__________________

PHYSICIAN REFERRAL INFORMATION

___________________________ (___)-____-____ _________________________ (_ __)-____-____

Primary Care Physician Phone # Referring Physician Phone #

How did you hear about us? ☐ Employer ☐ Family Member ☐ Yellow Pages ☐ Friend

☐ Insurance ☐ Other _______________ ☐ Doctor : ________________________

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITIES: This information is accurate and true to the best of my knowledge. I understand that I am resposible to pay for the service rendered, including reasonable attorney's fee and costs of collection in the even of default. I further understand that if payment becomes 30 days past due, delinquency charges at the lesser of the annual rate of 12%, or the maximum allowable will be due on delinquent from the date of payment was due. Insurance co-pay will be collected according to my insurance plan at the time of visit.

Signature _______________________________ **Date :_____/______/______**