ADULT PATIENT REGISTRATION

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http://daewingchowmd.portalforpatients.com

Patient Name:	**SSN:**		**Date:**	
Date of Birth:	**Age:**	**Sex:**	**Gender:**	**Orientation:**
Marital Status: __Single __Married __Divorced	**Account #:**			
Race: __Caucasian __African American __Asian __Hispanic __Other				
Employment Status:	**Employer:**			

Address:		**P.O. Box:**
City:	**State:**	**Zip:**
Winter Address:		
Resident at a Skilled Nursing Facility: YES or NO Name of Facility:		
Cell:	**Home:**	**Work:**
Email:	**Patient Portal Sign Up: YES or NO**	
Appointment Reminder (select ONE preference): Phone #: VOICE EMAIL TEXT		

Primary Care Doctor:	**Referring Doctor:**
Care Team Doctor & Address:	
Care Team Doctor & Address:	
Pharmacy Name & Address:	
Consent to send glasses RX to Optical Shop YES or NO Name of Facility:	

Please indicate a Contact Person for Emergencies and / or to Discuss health/surgical/ billing etc.

Name:	**DOB:**	**Address:**	
Relationship:	**Cell#:**	**Home#:**	**Cell#:**
Name:	**DOB:**	**Address:**	
Relationship:	**Cell#:**	**Home#:**	**Cell#:**

PRIMARY INSURANCE - NOTE WE DO NOT PAR WITH MEDICAID OR VISION INSURANCE

Company:	
Member ID#	
Subscriber: ___Self ___Spouse ___ Guardian	**SSN**:
Subscriber's Name:	**DOB:**
Subscriber's Address:	

SECONDARY INSURANCE - NOTE WE DO NOT PAR WITH MEDICAID OR VISION INSURANCE

Company:	
Member ID#	
Subscriber: ___Self ___Spouse ___ Guardian	**SSN:**
Subscriber's Name:	**DOB:**
Subscriber's Address:	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any remaining balance. I also authorize **David A. Ewing-Chow, MD, PLLC** or insurance company to release information vital to process my claims.

X_____ _____

Signature of Patient/Guardian/Responsible Party Date

Edited: 01/01/2019