Welcome to our practice, we look forward to meeting you at your consultation appointment.

In order to ensure we stay on time, we ask that you kindly fill out the enclosed registration documents and bring them with you to your appointment completed.

Dr. Chung charges a $175 consultation fee. If you choose to have a treatment on the day of your consultation or make a deposit towards a future surgical procedure, the consultation fee will be applied.

Our practice accepts the following forms of payment: MasterCard, Visa, Discover, Personal Check, Cash or Care Credit*. Sorry, we are unable to accept American Express.

Please contact the office at least 48 hours before your scheduled appointment if you need to cancel in order to avoid “no show” fees.

We look forward to meeting you.

Sincerely,

Julie Finn
Practice Manager
PATIENT REGISTRATION (please print)

Patient
Last Name ____________________________ First Name ____________________________ MI ______

Date of Birth ___________ Age ______ Social Security # ____________________ Martial Status____

Street Address ____________________________ City ____________________________

State ____________ Zip ____________ EMAIL ____________________________

Phone (H) ____________________ (C) ____________________ (W) ____________________

May we contact you at □ Home Phone □ Cell □ Work
□ Home Address □ Email

Occupation_____________________________________ Employer _________________________________________

PCP: ___________________________________________ Address: _______________________________________

Pharmacy: ___________________________ Address: __________________________________________________

How did you hear about us: ________________________________________________________________

Emergency Contact Name ____________________________ Phone Number ____________________________

If you are NOT a self-pay patient, please complete the remainder of the form

If Patient Is Under The Age of 18, We Require Responsible Party DOB & SSN

Primary Insurance _________________________________________________________________

Insurance ID# ____________________________ Group # ____________________________

Street Address ____________________________ City ____________________________ State ______ Zip ______

Name Of Person Who Carries Insurance ____________________________ SSN ____________________ DOB ______

Patient Relationship To Insured ______________________________________________________

Insured Employer __________________________________ City/State/Zip __________________________

ALL PROFESSIONAL SERVICES ARE CHARGED TO THE PATIENT. THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL. I HEREBY ASSIGN ALL MEDICAL AND SURGICAL BENEFITS TO INCLUDE MAJOR MEDICAL BENEFITS INCLUDING MEDICARE PRIVATE INSURANCE AND OTHER PLANS TO JEANNIE H. CHUNG, MD, P.C. I GIVE AUTHORIZATION TO RELEASE ANY INFORMATION TO MY INSURANCE COMPANY THAT IT MAY NEED.

Patient’s Signature (If 18 years or older) ____________________________ Date ______

Parent/Guardian’s Signature (If under 18 years) ____________________________ Date ______
Medical History

Date: ______________________

Name: ___________________________ DOB: ____________________

Allergies to Medications & or Foods, please detail reaction:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Medications/Vitamins of Homeopathic Regime, Topical Regime: (very important to note if take any
blood thinner/aspirin like medications, if so dose)
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Medical History: (very important to note if history of skin cancer, heart condition/pacemaker or bleeding
disorders)
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Family History: (very important to note if history of family skin cancer, particularly Melanoma)
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Surgical History:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Social History:
Smoker: _____, if yes how many cigarette’s/packs per day? Occupation/Sun Exposure:
_____________________________________________________________________________________
_____________________________________________________________________________________
Other:_______________________________________________________________________________