Benjamin N. Wan, MD, INC
595 Buckingham Way, Suite 500
San Francisco, CA 94132
Tel 415.665.6100 Fax 415.665.6101

PATIENT'S PERSONAL INFORMATION:

Patient's Name: _____ Date of Birth: _____
month/day/year

Sex: Male / Female Primary Language: _____

Names of any brothers and/or sisters: _____

Home Address: _____
Street City State Zip

Primary Phone Number: _____

PARENT/GUARDIAN INFORMATION:

Parent's Marital Status: Single Married Separated Divorce Widowed Partners

Parent #1: _____ Parent #2: _____

Relationship to Patient: _____ Relationship to Patient: _____

SS# (Last 4 digits): _____ Date of Birth: _____ SS# (Last 4 digits): _____ Date of Birth: _____

Employer: _____ Employer: _____

Occupation: _____ Occupation: _____

Cell Phone Number: _____ Cell Phone Number: _____

EMERGENCY CONTACT (other than parents):

Name: _____ Relationship: _____

Address: _____

Home Number: _____ Work Number: _____ Cell Number: _____

INSURANCE: Please present your insurance card to us at every visit

STATEMENT OF CONSENT FOR MEDICAL SERVICES AND FINANCIAL RESPONSIBILITY

I hereby give my consent for Benjamin Wan, M.D., to render medical services and care to my child. I understand that confidentiality of medical information and patient rights will be maintained as detailed by HIPAA regulations. I authorize the submission of any medical claims related to my child's care using standard medical office billing procedures, and I accept full responsibility for payment of medical services rendered.

Signature: _____ Date: _____

Print Name and Relationship: _____