212-233-2266
info@sohoent.com
198 Canal Street, Suite 403, New York, NY 10013

REGISTRATION FORM

***First, Last Name/名字:**	***Date of Birth / 出生日期:** ___/___/_____	**SSN / 社會安全號碼:** ____-____-_____
***Gender / 性別:** **M/F**	***Address / 地址:**	
***Phone / 電話:** ( ) ____ - _____	**Email / 電郵:**	
***Chief Complaint/症狀:**	***Preferred Pharmacy / 藥房:**	
Primary or Referral Physician / 家庭醫生: **Tel: ( ) ____ - _____** **Fax: ( ) ____ - _____**	**How did you find us?**	

INSURANCE INFORMATION

Insurance Company Name / 保險:	**ID Number (shown on card including prefix) / 保險號碼:**	
Group Number:	**Name, Address, and Birthday of Insured (if other than self)/ 保險擔保人的名字，地址，出生日期:**	
Relationship to Policy Holder / 保險擔保人關係: ☐ **Self** ☐ **Spouse/Partner** ☐ **Child**		
Name of Your Employer:	**Employer Address:**	
In Case of Emergency, notify / 急診通知人:	**Phone Number / 電話:** ( ) ____ - _____	**Relationship / 關係:**

Assignment of Benefits

I authorize the release of any medical information necessary to process this claim.

Signed (subscriber) _____
Date _____

Release of Information

I authorize payment of medical benefits to myself or the named provider

Signed (subscriber) _____
Date _____

Financial Responsibility

I understand that I am fully responsible for payment of all copays and deductibles.

Signature (Patient/Representative) _____
Relationship to Patient _____
Name of person signing form (if not patient)
_____
Date _____

Health Info Privacy Notice Acknowledgement

The HIPAA notice was made available to me in the doctors office or online.

Signature (Patient/Representative) _____
Relationship to Patient _____
Name of person signing form (if not patient)
_____
Date _____