WELCOME TO OUR OFFICE

HAUW T. HAN, M.D.
6770 Cincinnati Dayton Road, Suite 200
Liberty Township, Ohio 45044
513/755-8115

TODAY'S DATE ______________________

THANK YOU FOR CHOOSING OUR OFFICE.

In order to serve you properly, we will need the following information. All information will be strictly confidential.

First Name MI Last Name				Name to be called	Birthdate
Social Security Number	Sex M F	Martial Status S M W D	Age	Home Phone ( ) Cell Phone ( )	
Residence Address City State Zip					
Name of Employer				Business Phone ( )	
Employment Full Time Part Time Retired Unemployed			Occupation		
Do you have medical insurance? Yes No	Insurance Company Name				
Subscriber Name	Birthdate	Policy Number		Group Number	
Name of Spouse		Employer		Social Security Number	
Is there secondary insurance? Yes No	Insurance Company Name				
Subscriber Name		Policy Number		Group Number	
Person financially responsible for this account		Address			
Name and phone number of nearest relative or friend not living with you					
Primary Care Physician					

AUTHORIZATION

I, the undersigned, have insurance with ______________________________ and assign directly to Dr. Han all surgical and/or medical benefits for services rendered. I understand that I am financially responsible for all charge whether or not paid by insuranoce. I hereby authorize the doctor to release all information necessary to secure payment of benefits. The above subscriber hereby authorizes their insurance company to issue indemnity checks to the above listed medical provider for services provided by them.

SIGNATURE ______________________________ DATE