Andrew S. Baik, M.D. Daniel A. Baik, M.D. Meet Parikh, D.O.

1931 Oak Tree Road, Suite 202, Edison, NJ 08820 Tel: 732-744-9090 Fax: 732-744-1592

PATIENT INFORMATION (본인) **PLEASE FILL OUT ENTIRE FORM** **TODAY'S DATE: / /**

Name (성명):	Social Security # : - -	Date of Birth (생일): / /	Sex ☐ Male (남) (성별) ☐ Female (여)
Street Address (주소):	City:	State:	Zip Code:
Home Phone (집 전화): ( ) -	Cell Phone (핸드폰): ( ) -	Work Phone (직장 전화): ( ) -	
Please indicate Preferred Phone Number: Home ( )	Cell ( )	Work ( )	
Current Medications (현재 드시는 약):	Allergy to Medications (약에 의한 알러지):		
Race (인종):	Ethnicity (민족):		
Email Address:			

POLICY HOLDER (보험주) & INSURANCE (의료보험)

Policy Holder is (보험주와의 관계) ☐ Self (본인) / ☐ Spouse (배우자) / ☐ Parent (부모) / ☐ Other (기타):			
Name (성명):	Social Security # - -	Birth Date (생일): / /	Sex ☐ Male (남) (성별) ☐ Female (여)
Primary Insurance Name/Member ID# (의료 보험 1):			Co-Pay: $
Secondary Insurance (의료 보험 2):			Co-Pay: $

PHYSICIAN & PHARMACY INFO (담당 의사 선생님 & 약국)

Primary/Referring Physician Name (주치의 선생님):	Tel :
How did you find us?	
Pharmacy Name (약국):	Tel :

EMERGENCY CONTACT INFORMATION (응급시 연락처)

Contact Name (성명):	Relationship (관계):
Primary Phone Number: ( ) -	Secondary Phone Number: ( ) -

Financial Policy

I understand that I am financially responsible for all charges for services rendered, including the balance remaining after payment of possible insurance benefits. I authorize payment of medical benefits to myself and the names provided for professional services rendered. I authorize the release of any medial information necessary to process this claim and should my account be submitted to a collection agency my treatment record may become a matter of public record. I am also fully responsible for all charges including co-payments, annual deductible, and co-insurance. All balances overdue of sixty days will be sent to collection without notice.

Dr. Andrew S. Baik has financial interest at Oak Tree Surgery Center (1931 Oak Tree Road Suite#202 , Edison, NJ 08820)

By signing below, I indicate that I have read, understand, and accept the statements and policies as outlined above.

Signature: X_____ **Date:** _____

We appreciate your cooperation. Our office runs more efficiently with your help and therefore enables us to give our patients optimal treatment.