HERBERT H. LEE, M.D., M.P.H., INC.
MEDICAL CLINIC

15785 Laguna Canyon Rd, Suite #230, Irvine, CA 92618
Tel: (949) 552-9628 Fax: (949) 329-3958

PATIENT REGISTRATION

Patient Name **Social Security #**

Last MI First
Date of Birth **Marital Status** **Email**

Address **Telephone**

Street City State Zip

INSURED PERSON (IF NOT PATIENT)

Name **Social Security #**

Last MI First
Date of Birth **Telephone** **Email**

Address

Street City State Zip

EMERGENCY CONTACT

Name **Telephone**

Address

Street City State Zip

INSURANCE

Primary Insurance **ID#** **Plan#** **Group#** **Co-Payment**

Address **Telephone**

Street City State Zip
Secondary Insurance **ID#** **Plan#** **Group#** **Co-Payment**

Address **Telephone**

Street City State Zip

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original.

Date: **Signature: X**

I hereby authorize **Dr. Herbert Lee** to apply for benefits on my behalf for covered services rendered by him. I request that payment from my insurance company be made directly to **Dr. Herbert Lee** (or to the party who accepts assignment). I certify that the information I have reported with regard to my insurance coverage is correct. I understand that I am responsible for knowing my benefits/coverage and will be financially responsible for all charges not covered by my insurance company. I permit a copy of this authorization to be used in place of the original. Either my insurance company or I may revoke this authorization at any time of writing.

Date: **Signature: X**

Note: Incomplete insurance information may cause billing delay and become your responsibility