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

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PATIENT REGISTRATION

Patient Name | Social Security #

Address | Street | City | Zip | TEL

Date of Birth | Marital Status | Email

PATIENT or INSURED PERSON'S EMPLOYER

Employer Name

Address | Street | City | Zip | TEL

Occupation

INSURED PERSON (If not patient)

Person Name | Social Security #

Address | Street | City | Zip | TEL

Date of Birth | Email

EMERGENCY CONTACT PERSON NOT AT SAME ADDRESS

Name

Address | Street | City | Zip | TEL

INSURANCE

#1. Primary Insurance Co. | ID# | Plan# | Group# | Co-Payment

Address | Street | City | Zip | TEL

#2. Secondary Insurance Co. | ID# | Plan# | Group# | Co-Payment

Subscriber | Relationship | Employer

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT BENIFITS

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/her. 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 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 in writing.
Date: _____ **Signature:** X_____

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