Edward C. Lee, M.D. Inc.
4906 El Camino Real, Suite A
Los Altos, CA 94022
650-967-1770

NEW PATIENT INFORMATION SHEET PLEASE PRINT

Name_____ Age____ Sex M F
First Middle Last

SS#_____ Birthdate_____ Marital Status: M S D W

Address_____

City_____ State_____ ZIP_____

Home Phone_____ Work Phone_____ Cell_____

Employer_____ Address_____

Occupation_____ REFERRED BY_____

LIST ANY ALLERGIES TO MEDICATIONS_____

PRIMARY CARDHOLDER (IF DIFFERENT FROM ABOVE)

Name_____ Relationship to Patient_____ Birthdate_____

SS#_____ Employer & Address_____

City_____ State_____ Zip_____ Work Phone_____

Home Phone_____ Cell Phone_____

EMERGENCY CONTACT_____ **PHONE**_____

Please review and initial each statement indicating your acknowledgement and agreement

Insurance: If you are not insured by a plan that we participate with, you will be considered a cash patient and payment in-full will be collected at each appointment. If you have any questions regarding coverage or insurance determination please contact your insurance Company.

Co-payments: All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance Co. Failure on our part to collect co-payments at the time of service may be detrimental to our preferred-provider contract with your insurance company.

Co-insurance/Deductibles: Once we bill your insurance company for services rendered they will determine what your out-of-pocket cost will be for any co-insurance and deductible. Once we receive this information from you insurance we will bill you for your patient portion. Payment for these charges is due upon receipt of statement. You will need to contact your Insurance Co. if you have questions regarding your out-of-pocket costs.

Nonpayment: If you have an outstanding balance you will be sent a statement. Balances are due at the time of receipt of your statement. Failure to pay your balance in-full will result in a late charge of 1.5% assessed to the balance each month. Please be aware that we will not carry a balance for more that 120 days, failure to pay your balance, in-full, within this time frame will result in your account being sent to a outside collection agency. Please be advised that habitual collection issues may result in your and any immediate family members being discharged from the practice.

_____ I authorize the release of any information, including diagnosis and the records of any treatment or examination rendered to my child or me during the periods of such care, to third party payers and/or other health care practitioners.

_____ I assign any payment/benefits from my insurance company(ies) to: Edward C. Lee MD, Inc.

Print Patient Name **Signature of Patient** (parent/guardian if minor) **Date**