909 S Santa Anita Ave., Ste B
Arcadia, CA 91006

Tel: 626-623-6191
Fax: 626-2265858

Wenche Chung, MD & Kuoting Lee, LAc APC
PATIENT INFORMATION

NAME: _____ , _____
Last Name **First Name**

Gender: ☐ **Male** ☐ **Female**

Date of Birth: _____ / _____ / _____

Martital Status: ☐ **Single** ☐ **Married** ☐ **Other**

Driver's Lincese Number: _____

Occupations: _____

Home Address: _____ _____
**Street** **Apt#**

_____ _____ _____
City **State** **Zip Code**

Phone Numbers:

Home: (_____) _____ - _____

Work: (_____) _____ - _____

Cell: (_____) _____ - _____

Email Address (Optional): _____

Do you have a Primary Doctor? ☐ **Yes** ☐ **No**

If Yes, Primary Doctor's Name: _____ **Phone:** _____

Are you claiming Worker's Comp? ☐ **Yes** ☐ **No**

Referring Physician: _____ **Phone:** _____

Do you have PPO Insurance? ☐ **Yes** ☐ **No**

If Yes, Insurance Company Name: _____ **Phone:** _____

Who referred you to our clinic? _____