Wynnshang C. Sun, M.D., APC

9850 Genesee Avenue • Suite 870
La Jolla, California 92037 • (858) 452-7040

Patient Registration

Name _____ Home phone (_____) _____

Address _____ Cell phone (_____) _____

City/State/Zip _____

Social Security Number _____ Date of Birth _____

Employer _____ Work phone (_____) _____

Emergency Contact _____ Relation _____

Address _____ City/State/Zip _____

Phone Number (_____) _____ Referred by _____

Insurance and Billing Information

Insurance Company _____ Address _____

Subscriber Name _____ I.D. # _____ Group # _____

Insurance Company _____ Address _____

Subscriber Name _____ I.D. # _____ Group # _____

Assignment of Insurance Benefits

I hereby authorize direct payment of surgical/medical benefits to Dr. Sun, for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Authorization to Release Information

I hereby authorize Dr. Sun to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

Medicare/Medicaid

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original

Patient Name _____ Date _____

Patient Signature _____