JiKi Medical Associates, LLC
JiYon Hwang-Ki, M.D.*
15200 Shady Grove Road Suite 108, Rockville, Maryland 20850,
Tel: 301-610-6630 Fax: 301-610-5431

PATIENT NAME: _____ DATE OF BIRTH:_____
SEX:_____
Gender Identity:_____
Sexual Orientation:_____
ADDRESS: _____ _____
_____
(CITY) (STATE) (ZIP CODE)
HOME #: _____
CELL #: _____
WORK #:_____
EMAIL ADDRESS:_____@_____

PHARMACY NAME: _____
PHARMACY TEL #: _____
ALLERGIES TO MEDICATION:_____

MEDICAL INSURANCE INFORMATION
PRIMARY INSURANCE:
NAME OF COMP: _____ POLICY NO:_____
NAME OF POLICY HOLDER: _____ DATE OF BIRTH:_____
SECONDARY INSURANCE:
NAME OF COMP: _____ POLICY NO:_____
NAME OF POLICY HOLDER: _____ DATE OF BIRTH:_____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name:_____ Relationship: _____

Phone: Home:_____ Cell: _____

I, THE UNDERSIGNED, HAVE INSURANCE COVERAGE WITH_____ AND ASSIGN DIRECTLY TO DR. JI YON HWANG-KI ALL MEDICAL BENEFITS. IF ANY, OTHER WISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS.

SIGNATURE:_____ DATE:_____