

Galant & Lin, MD's Inc.

1201 W. La Veta, Suite 501  
Orange, Ca 92868  
714-771-7994

340 W. Central Ave. #112  
Brea, Ca 92621  
714-256-2600

4050 Barranca Pkwy. #200  
Irvine, Ca 92604  
949-653-0299

Date: \_\_\_\_\_ Acct# \_\_\_\_\_  
Last Name: \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Gender : M F  
Patient Address: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_\_) \_\_\_\_\_

Responsible party information:

Last Name: \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ SS# \_\_\_\_\_  
Employer: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Emergency Contact not living with you: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

You are required to provide a copy of your insurance card, or a completed claim form. You account will be considered cash if this is not provided.

Insurance name: \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Name of insured: \_\_\_\_\_ Date of birth \_\_\_\_\_ Gender M F  
ID# \_\_\_\_\_ Group # \_\_\_\_\_

I certify that the information listed above is current and correct.

Signature of patient or responsible party \_\_\_\_\_ Date \_\_\_\_\_