MICHAEL K. KWOK M.D.
INTERNAL MEDICINE
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REGISTRATION FORM

(Please Print)

Today's date:	Referred By:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs. ❑ Dr.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Birth date: / /	Age:	Sex: ❑ M ❑ F	Social Security #:

Street address:	Home phone: ( )

City:	State:	ZIP Code:	Cell Phone: ( )

Occupation:	Employer:	Employer phone #: ( )

E-mail:

RELEASE OF MEDICAL INFORMATION

Is it okay to leave messages on your phone?: ☐ Yes ☐ No ☐ Home ☐ Cell	Is it okay to discuss your health information with another person? ☐ YES ☐ WHOM? ☐ NO

Ethnicity: ❑ Hispanic/Latino ❑ Non Hispanic/Non-Latino ❑ Decline to State	Race: ❑ American Indian/Alaska Native ❑ Asian ❑ African American/Black ❑ Native Hawaiian/Pacific Islander ❑ White ❑ other ❑ Decline to State
Primary Language:	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Cell/Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize Michael Kwok, M.D. to release my medical information to any physician, hospital or any other entity if necessary for my medical care. I authorize Michael Kwok M.D. to release any information necessary to process my insurance claims.

_____ _____

Patient/Guardian signature *Date*