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Date _____ Referred by: _____
(Doctor, friend's name, TV, Phone Book, newspaper)

May we send a thank you note to the person who referred you? Yes _____ No _____ Initial _____

Patient's Information

Patient's Name:

_____ Last First Middle

Address: _____

City _____ State: _____ Zip: _____

Age: _____ Birth Date: _____ Sex: _____
M/D/Y Female/Male

Drivers License: _____ SS#: _____

Home# _____ Work# _____ Cell# _____

E-Mail Address: _____

Occupation: _____ Employer: _____

Patient's Primary Care Physician: _____

Reason for Visit: _____

Emergency Contact

Emergency Contact Person: _____

Relationship: _____ Phone: _____

Insurance Benefits

I request the payment of authorized insurance benefits to be made to this office on my behalf for any services furnished me by Dr. Yanase in his offices including physician services. I authorized any holder of medical or other information about me to release to the insurance company(s) and its agents any information needed to determine these benefits for related services. I authorize Dr. Yanase to release medical information necessary information necessary to process my insurance claims (s).

Signature: _____ Date: _____

Photos

In connection with the medical services received from Dr. Yanase, I consent that photographs may be taken of me to be used for medical records and publication in print or for the purpose of medical education, under private or commercial sponsorship, provided I am not identified by name. I waive all rights to claims for payment or royalties in connection with the above publication or broadcast.

Signature: _____ Date: _____

Payment

Payment is required at the time of service. Should this account become delinquent, I will be responsible for any and/or all legal fees, court cost, and collection charges.

Signature: _____ Date: _____