

## WELCOME TO THE OFFICE OF DR. CURTIS WONG

How were you referred to our office? \_\_\_\_\_

What are you consulting for today? \_\_\_\_\_

Legal Name: \_\_\_\_\_ Nick name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender M F Marital status M S D W P Email address: \_\_\_\_\_

Address: \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

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

Do you currently or did ever you smoke? Yes  No  Language: \_\_\_\_\_

Preferred pharmacy, ***name and zip code:*** \_\_\_\_\_

**We require a confirmation for all appointments, this includes consults, pre-op, post-op, and office procedures.**

What telephone number do you wish to use? \_\_\_\_\_

If you are not available, may we leave a message with the person/voicemail answering the phone? Yes No

May we contact you by email or text with reminder calls, office updates, or requested information? Yes No

Employer: \_\_\_\_\_ Type of work: \_\_\_\_\_

Name(s) we can release medical information to: \_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**(Name and relationship)**

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES AND PAYMENT IS DUE AT OR BEFORE TIME OF SERVICES. This shall remain valid and effective from the date of signing until revoked in writing and photocopy of this form shall be deemed as valid as the original.

PATIENT, PARENT OR GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

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Phone: (530) 215-1118 Fax: (888) 709-1015