Patient Information Dr Henry Wang, MD
MVA (Lien)

Please write in English **escriba en inglés por favor** **請用英語寫**

DATE OF BIRTH (Fecha de nacimiento, 生日) ________________ SEX (SEXO, 性別) _____

SOCIAL SECURITY NUMBER (NÚMERO SEGURO SOCIAL, 社會安全號碼) ________________________________

Last Name (Appellidos, 姓) ____________________________ First (Nombre, 名) _________________________

HOME ADDRESS (Domicilio, 地址) ____________________________________ CITY _________________

STATE _________ ZIP code ______________

HOME PHONE (TELÉFONO, 家庭電話) ( ) _____________________ cell phone ( ) __________________

MARITAL STATUS (ESTADO CIVIL, 婚姻状况) _____________

Spouse Last Name (appellido del esposo/a, 姓) _________________________
First (nombre del esposo/a, 名) _____________________

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PRIMARY MEDICAL INSURANCE (ASEGURANZA PRIMARIO, 主要醫療保險) _____________________________________

NAME OF INSURED (NOMBRE DEL ASEGURADO, 保險人) _________________________

DATE OF BIRTH (Fecha de nacimiento, 生日) ______________

SECONDARY MEDICAL INSURANCE (ASEGURANZA SECUNDARIO, 次要醫療保險) _________________________________

NAME OF INSURED (NOMBRE DEL ASEGURADO, 保險人) _________________________

DATE OF BIRTH (Fecha de nacimiento, 生日) ________________

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CHIROPRACTOR NAME (QUIROPRACTICO, 脊椎骨医生) ____

PHONE (NÚMERO DE TELÉFONO, 電話號碼) ( ) ___________________

ATTORNEY NAME (NOMBRE DEL ABOGADO , 律師名) ____

PHONE (NÚMERO DE TELÉFONO, 電話號碼) ( ) ___________________

DATE OF ACCIDENT (FECHA del ACCIDENTE, 事故的日期): ______/_______/__________

I HAVE COMPLETED THIS FORM FULLY AND COMPLETELY. I CERTIFY THAT I AM THE PATIENT OR DULY AUTHORIZED GENERAL AGENT OF THE PATIENT AUTHORIZED TO FURNISH THE INFORMATION. I UNDERSTAND THAT EVEN THOUGH I HAVE SOME TYPES OF INSURANCE COVERAGE, I AM RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICE. I HEREBY ACKNOWLEDGE THAT I HAVE BEEN PRESENTED WITH A COPY OF **WANG MEDICAL'S NOTICE OF PRIVACY PRACTICES.**

SIGNATURE OF RESPONSIBLE PARTY ____________________________________ **DATE** ____________________

DOCTOR'S LIEN

Henry Wang, MD
Internal Medicine
1346 S. Decatur Blvd
Las Vegas, NV 89102
Phone: (702)889-8355 Fax: (702)889-8699

TO ATTORNEY: ______________________________

Phone: ______________________________

Fax: ______________________________

Date of Accident: ______________________________

State of Accident: ______________________________

I hereby authorize the above Doctor to furnish you, my attorney(s), with a full report of the case history, examination, diagnosis, treatment, and prognosis of myself in regard to the accident in which I was involved.

I here authorize you and direct you, my attorney(s), to pay directly to said Doctor such sums as may be due and owing him for medical services rendered to me both by reason of the aforesaid accident and by reason of any other bills that are due and owing to his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said Doctor. I hereby further give a lien on my case to said Doctor against any all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney(s), or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said Doctor for all medical bills submitted by him for services rendered to me and that this agreement is made solely for said Doctor's additional protection and in consideration of pending payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

______________________________ ______________________________
Date Patient or Responsible Party Signature

____
Patient's Name(Print)

The undersigned being attorney(s) of record for the above patient does hereby agree to observe all of the terms and conditions of the above lien and agree(s) to withhold such sums from any settlement, judgment or verdict as may be necessary to protect the said Doctor named above.

______________________________ ______________________________
Date Attorney's Signature

ATTORNEY: Please date, sign and fax back to us. Thank you.