



Michael Moon, M.D.  
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**PATIENT REGISTRATION INFORMATION**

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Last** \_\_\_\_\_ **First** \_\_\_\_\_ **Middle** \_\_\_\_\_  
**Age:** \_\_\_\_\_ **Sex:** \_\_\_\_\_ **SS#:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Home Telephone:** (\_\_\_\_) \_\_\_\_\_ **Cell Phone:** (\_\_\_\_) \_\_\_\_\_

**E-Mail:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**Referred by:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**Primary Insurance:** \_\_\_\_\_ **Secondary Insurance:** \_\_\_\_\_

**Work Comp:** \_\_\_\_\_ **Personal Injury:** \_\_\_\_\_ **Private Insurance:** \_\_\_\_\_

**Date of Injury:** \_\_\_\_\_ **Attorney Assigned to Case:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

I understand that patients who carry medical insurance should remember that professional services are rendered and charged to the patient, not the insurance company. In the event insurance payments are received directly by me for services rendered that have not been paid for, I promise to immediately sign over and forward those payments to the doctor. I accept financial responsibility for all charges incurred. If my account has to be referred for outside collection, I will be charged a service charge. AUTHORIZATION: I hereby authorize payment directly to Michael Moon, M.D., AMC for medical services rendered and to release any information acquired in the course of my examination or treatment to my insurance company.

**Patient/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_