2120 Truxtun Ave.
Bakersfield, CA 93301
Phone: 661-327-3638 Fax: 661-327-2869

Thank you for choosing us as your Healthcare Provider. To simplify the process on your first visit please complete the enclosed patient information forms prior to your arrival.

THE FOLLOWING ARE VERY IMPORTANT FOR YOU TO BRING WITH YOU FOR YOUR APPOINTMENT:

- ✔ Valid form of ID and current insurance card.
- ✔ All CT or X-RAY film (CD format is acceptable) as well as the written report.
- ✔ Lab work including PSA reports from your referring doctor.
- ✔ Patient information forms.

REMINDER:

- ➢ Please note that if you are more than 15 minutes late, you will need to reschedule.
- ➢ Urine sample will be requested upon arrival.

We look forward to seeing you and making you visit a pleasant one.

Sincerely,

The staff at Danny L. Huynh, M.D. Urology

Patient Registration Information

Patient Information

Name: ____Age: _________

DOB: _____________ SS#: _________________ DL #:_______________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Sex: ☐ M ale ☐ Female

Address: _________________________________ City: ____________________

State: ________ Zip: _____________ Home Phone: ______________________

Cell Phone : ___________________ Email Address: ___________________________

Mailing Address (If different from above): _______________________________________

City: _____________________ State: ____________ Zip: ________________

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Hispanic/Latino ☐ Other __________

Ethnicity: ☐ Hispaic / Latino ☐ NOT Hispanic / Latino

Language: ☐ English ☐ Spanish ☐ Other __________________

Employment Status: ☐ Employed ☐ Retired ☐ Unemployed ☐ Other ________________

Occupation: ________________________ Employers Phone: ______________________

Do you have an “Advanced Directive”, also known as a “Living Will” or a Durable Power of attorney for Health Care”? ☐ Si ☐ No (If yes, please provide a copy for your medical record)

Primary Care Dr: ___________________ Office#: ____________ Fax #:____________

Preferred Pharmacy: ___________________ Address: _____________________________

Pharmacy Phone: __________________ Pharmacy Fax: ______________________

Patient Registration Information continued

Spouse Information

Name: ______________________________ DOB: _____________

Address: ______________________________ City: ______________________

State: _____ Zip: _______ Phone: _____________ SS#:_________

Employment Status: ☐ Employed ☐ Retired ☐ Unemployed ☐ Other _______________

Employee: ________________________ Employers Phone: ______________________

Emergency Contact Information

Provide information on the nearest adult relative, not your spouse, who is NOT living with you.

Name: __________________________ Relationship: ________________________

Home Address: ____________________________ City: __________________

State: _______________ Zip: _______________ Phone: _____________________

Authorization to Allow Access to Medical Information

I authorize the release of information that includes all medical records, billing records and all phone calls from Dr. Danny L. Huynh, M.D.

Provide My Medical Information Upon Request To:

Name	DOB	Phone Number	Relationship to Patient

The information that i request includes all medical records, billing records and all phone calls regarding the patient's care in our office.

**If you do not wish to authorize access of your medical information to anyone, initial here: _____