Infectious Disease
Associates of Orange County

Puneet K. Chahal, M.D.
Tuan Ta, M.D.

PATIENT INFORMATION

Name: ____ Age: _____ Date of Birth:_________________

I identify my gender as: □ Male □ Female □ Transgender □ Prefer not to disclose

Street Address: _____________________________ City: __________________ Zip Code: ____________

Mobile Number: (____) _______________________ Work Number: (____) _______________________

Home Number: (____) ___________________ Preferred Route of Contact: □ Mobile □ Work □ Home

May confidential messages be left on your voicemail, at the preferred route of contact? □ Yes □ No

May we send SMS text messages (appointment reminders) to your mobile number? □ Yes □ No
(Additional charges may apply. Please contact your mobile phone carrier for further details.)

Email Address (for patient portal enrollment): ____

Emergency Contact Name: __________________________________ Relation: ____________________

Emergency Contact Phone Number: (____) ________________ Consent to contact (if necessary): _____

Preferred Pharmacy Name: ___________________ Pharmacy Phone Number: (____) _______________

Pharmacy Address: ____

REFERRAL INFORMATION

Referring Physician Name: ____

Referring Physician Phone Number: (____) ____________________ Fax: (____) ____________________

Primary Physician Name (if different than above): ____

Primary Physician Phone Number (if applicable): (____) _______________ Fax: (____) _______________

INSURANCE INFORMATION

Please hand insurance card and ID to receptionist.