PATIENT REGISTRATION

How did you hear about our office?_____

Name:_____

Date of Birth:_____

Address:_____

City, Zip:_____

Phone: (Home)_____ **Cell #:**_____

Social Security #:_____

Employer/Occupation:_____

Work #:_____

Marital Status: **Single** **Married** **Divorced** **Widowed**

Spouse's Name:_____

Emergency Contact:_____ **#:**_____

If under 18:
Parent/Guardian_____ **#:**_____

(over)

INSURANCE/BILLING INFORMATION

Medical Insurance Co.:_____

Subscriber's Name:_____

Secondary Insurance?_____

Do you have Vision Insurance? Yes No

Vision Insurance Co.:_____

Please present all Insurance Cards to Receptionist for copies of Insurance Numbers

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical office call benefits to Roxana Hakimzadeh, M.D., for services rendered by her in person or under her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Hakimzadeh to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

MEDICARE * MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize the release of all records on request. I request that payment of authorized benefits be made on my behalf.

Patient Name (print):_____

Signature:_____

Guardian:_____

Date:_____