

PATIENT INFORMATION

Referred by: _____

Primary Care Physician: _____

Patient: _____
(Last Name) (First Name) (Middle Initial)

Address: _____
(Street) (City/State) (Zip Code)

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Sex: M F Marital Status: S M W D Separated

SSN: _____ Patient's Employer: _____ Student Status: Full-time Part-time N/A

Emergency Contact Person: _____ Phone No: _____

Relationship to Patient: _____

Person Responsible for Balance (if different from patient, complete below): _____

Responsible Party's Date of Birth: _____

Responsible Party's Address: _____

SSN: _____ Phone No.: _____ Relationship to Patient: _____

INSURANCE INFORMATION (COPIES OF INSURANCE CARDS REQUIRED)

Primary Insurance: _____ Effective Date: _____

Name of Insured: _____ Relationship to Patient: _____

Insured's Date of Birth: _____ Insured's I.D. No: _____ Group No.: _____

Insured's Home Address: _____ Phone No.: _____

(If different from patient's address)

Insured Party Employed by: _____ Phone No.: _____

Employer's Address: _____

Secondary Insurance: _____ Effective Date: _____

Name of Insured: _____ Relationship to Patient: _____

Insured's Date of Birth: _____ Insured's I.D. No: _____ Group No.: _____

Insured's Home Address: _____ Phone No.: _____

(If different from patient's address)

Insured Party Employed by: _____ Phone No.: _____

Employer's Address: _____

ASSIGNMENT OF INSURANCE INFORMATION & BENEFITS/RELEASE OF MEDICAL INFORMATION: I hereby authorize Etie Moghissi, MD to administer / perform any medical and or surgical procedure deemed necessary, and authorize release of information needed to secure payment. I authorize that all benefits by my insurance company be paid directly to Etie Moghissi, MD, and understand that I am financially responsible for all charges incurred that are not covered in full by my insurance. In addition, I hereby authorize the release of all applicable medical information including & without limitation copies of all records and test results produced to the designated attending, referral, and/or follow-up physicians and such other health care practitioners who are part of my health care team.

Signature of Responsible Party: _____ **Date:** _____