Patient Registration Form

CHART NUMBER:_____

PATIENT'S INFORMATION:

.....
(FIRST) (MIDDLE) (LAST)

.....
(STREET)

.....
(TOWN/CITY) (STATE) (ZIP CODE)

.....
(HOME TELEPHONE)

PATIENT'S WORK PHONE NUMBER:.....

PATIENT'S CELL PHONE NUMBER:.....

PATIENT'S E-MAIL :.....

HOW WOULD YOU PREFER TO BE CONTACTED?
(please circle below)

Home Phone Cell Phone Work Phone Email

PATIENT'S SOCIAL SECURITY #: .....

PATIENT'S DATE OF BIRTH IS:.....

PATIENT'S GENDER : MALE FEMALE

PATIENT'S MARITAL STATUS : **S M W D SEP**

EMPLOYMENT STATUS: **Student P/T Student**

Employed Unemployed Retired Disabled

Occupation : .....

EMERGENCY CONTACT NAME : .....

RELATIONSHIP TO PATIENT.....

EMERGENCY CONTACTS TELEPHONE

NUMBER:.....

PATIENT'S PRIMARY CARE PHYSICIAN NAME:

DR. : .....

NOTE **: We are now REQUIRED to have a copy of your driver's license and insurance card for legal identification and proof of coverage. If the patient is a child, then a copy of one of the parents driver's license MUST be submitted. NO EXCEPTIONS!!**

INSURANCE PLAN INFORMATION:

PATIENT'S INSURANCE COMPANY: .....

CO-PAYMENT : $ .....

POLICY HOLDER'S INFORMATION:

(A POLICY HOLDER IS THE PERSON WHOSE INSURANCE PLAN IS ISSUED UNDER HIS/HER NAME, USUALLY THROUGH AN EMPLOYER)

POLICY HOLDER'S NAME:.....

POLICY HOLDER'S DATE OF BIRTH:.....

POLICY HOLDER'S GENDER: MALE FEMALE

POLICY HOLDER'S RELATIONSHIP TO PATIENT:

SELF FATHER MOTHER SPOUSE

POLICY HOLDER'S EMPLOYER:.....

PHARMACY NAME:.....

PHARMACY ADDRESS:.....

PHARMACY PHONE NUMBER:.....

PER GOVERNMENT REGULATIONS-PLEASE CIRCLE THOSE WHICH APPLY TO PATIENT:

1. **RACE: (please circle)**

White Black Asian American Indian Hispanic

Multiracial

2. **ETHNICITY (Ex.: American, Puerto Rican, Mexican).....**

3. **PRIMARY LANGUAGE: (Please Circle)**

English Arabic Spanish French Other .....

.....

ASSIGNMENT OF BENEFITS

I authorize payment of the medical benefits directly to Mazin A. Dhafir, M.D. for professional services rendered.

SIGNED .....DATE .....

WHO IS RESPONSIBLE FOR PAYING YOUR BILLS ?

SELF HUSBAND WIFE PARENT

LEGAL GUARDIAN (other than above)

NAME OF RESPONSIBLE INDIVIDUAL:

.....

RELEASE OF INFORMATION

I authorize the release of any information necessary to process all claims and bills related to my healthcare.

SIGNED ..... DATE .....

I understand that I am responsible for all bills incurred in this office by me or any one of my children or spouse.

SIGNED ..... DATE :.....