PATIENT INFORMATION FORM

Please give name as listed on your primary insurance card.

Last Name______________________________First Name__________________________MI:__________ Male / Female

Social Security #___________________Date of Birth ___/___/___ Age _________ Driver's Lic. # ___________________

Physical Address______________________________________ City _____________________State ____ Zip _________

Mailing Address _______________________________________ City _____________________State ____ Zip_________

Phone # _________________________ Work #____________________________ Cell #__________________________

Referred by ___________________ Marital Status: M S W D Email Address____________________________
*Do we have your authorization to leave a private message or an appointment reminder at your Home phone #? **YES NO**
*Do you authorize the office to speak to anyone else regarding your medical care? **YES NO**

RESPONSIBLE PARTY INFORMATION - Person financially responsible - Parent/Guardian if pt. is a minor

Last Name______________________________First Name__________________________MI__________ Male / Female

Relationship ___________________ Phone # ________________ Work #______________ext_____ Cell #___________

Mailing Address _______________________________________ City _____________________State ____ Zip_________

Employer Name____________________________ Employer Address ______________________ Phone #____________

INSURANCE INFORMATION

Primary Insurance____________________________ ID/Gp#______________________/________**Please Provide Card**

Subscriber name ___________________________ DOB _____________ Relationship to pt ___________________ M / F

Secondary Insurance____________________________ ID/Gp#___________________/________**Please Provide Card**

MISCELLANEOUS INFORMATION - PATIENT

Occupation __________________ Student? Y / N Employer Name ___________________________ Fulltime/Part-time

Employer Address______________________________________ City _____________________State ____ Zip ________

Emergency Contact ____Relationship ____________________

Best Phone # (s)____

Nearest Relative not living with you _______________________________________Relationship ____________________

Best Phone # (s)____

I hereby authorize the processing of the medical insurance either by electronic or manual method by **Kathryn Najafi-Tagol, MD**. My signature below authorizes payment of all major medical and/or surgical benefits to which I am entitled from the listed insurer(s) to **Kathryn Najafi-Tagol, MD**. I further authorize assignee to release all medical and/or insurance claim information necessary to secure payment(s). I recognize my financial obligation of any co-insurance, deductible, and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing.***Signature____ **Date**____________

MEDICARE SIGNATURE ON FILE (Sign below)

I request that payment of authorized Medicare benefits be made on my behalf to **Kathryn Najafi-Tagol, MD** for any services furnished to me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financial Administration and its agents any information needed to determine these benefits payable to related services. I understand my signature below requests that payments be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 or the HCFA1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider/supplier agrees to accept the charge determined by the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.**Signature**____ **Date**____________