Davood

Family Medicine

Personalized Care for every stage of Life

PATIENT REGISTRATION FORM

**Today's Date: _____

PATIENT INFORMATION: (Please use full legal name, no nicknames)

*Last Name_____*FirstName_____MI_____

*Address:_____

*City: _____ State: _____Zip:_____

*Home Phone #: _____ Cell Phone#:_____

*Social Security #_____

*Date of Birth: _____ Age: _____ *Sex: _____ Marital Status: _____

*Drivers Lic#: _____

*Employer Name and Address:

_____

_____ Work Phone #: _____

*E-mail Address: _____

*Emergency Contact Name: _____

*Emergency Phone #: (_____) _____-_____

***Please tell us how you heard about us**: _____

*Referred by_____

GUARANTOR INFORMATION: (List person or insured name responsible for bill

*Relationship of Guarantor to Patient: Self _____ Spouse _____ Parent _____ Other

_____

*Last Name: _____ *First_____

*Address:_____

City: _____ State: _____Zip_____

*Home Phone #: _____*Social Security #: _____

*Date of Birth: _____ Age: _____ *Sex: Female _____ Male _____

*Employer Name and Address:

_____

_____

*Work Phone #: (_____)_____-_____

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

PRIMARY INSURANCE:

Plan Name : _____

*Insured's Name: _____

Insured's Social Security #: _____

*Insured's Date of Birth:_____

*Policy / ID #: _____ *Group #: _____

Effective Date: _____

Claims Address

_____

Phone#_____

SECONDARY INSURANCE:

Plan Name : _____

*Insured's Name: _____

*Insured'sSocialSecurity_____*Insured'sDateBirth_____

*Policy / ID #: _____ *Group #: _____

* Effective Date: _____

Claims Address

_____

Phone_____

***REQUIRED FIELDS-PLEASE COMPLETE FOR BILLING. *ATTACH COPY OF INSURANCE CARDS.**

PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS

Patient Name: _____

Date of Birth: _____

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Davoodi Family Medicine or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Davoodi Family Medicine is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Davoodi Family Medicine or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of the Davoodi Family Medicine Information Privacy Policy. I hereby authorize Davoodi Family Medicine or the physician individually to release any of my or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize Davoodi Family Medicine or a representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Davoodi Family Medicine to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed by my physician or his or her designee.

PATIENT SIGNATURE: _____ DATE: _____

GUARANTOR SIGNATURE: _____ DATE: _____

(If different from patient)

GUARANTOR NAME (Please Print):

_____