

## PATIENT INFORMATION

|                                  |                            |                                |                                |                |
|----------------------------------|----------------------------|--------------------------------|--------------------------------|----------------|
| Last Name                        |                            | First Name                     |                                | Middle Initial |
| Street Address                   |                            | City/State/Zip                 |                                | Home Phone #   |
| Work Phone #                     | Mobile Phone #             | E-Mail                         | Emergency Contact/Phone #      |                |
| Social Security #                | Date of Birth (mm, dd, yy) | Single/Married/Divorce/Widowed | Primary Care Physician/Phone # |                |
| Preferred Pharmacy Name/ Phone # |                            | School Name/ Phone #           | Do you have a living Will?     |                |
| Employer                         | Employer Address           |                                | Employer Phone #               |                |

## RESPONSIBLE PARTY / BILLING INFORMATION

|  |          |                  |                   |                |
|--|----------|------------------|-------------------|----------------|
| Last Name                                |          | First Name       |                   | Middle Initial |
| Street Address (if different from above) |          | City/State       |                   | Zip Code       |
| Home Phone #                             | Employer | Employer Phone # | Social Security # |                |
| Employer Address                         |          |                  |                   |                |

## PRIMARY INSURANCE INFORMATION

|                    |                        |                  |                   |  |
|--------------------|------------------------|------------------|-------------------|--|
| Name of Company    |                        | Office Co-Pay \$ | Insurance Phone # |  |
| Group Number       |                        | Policy Number    |                   |  |
| Insurance Address  |                        | City/State       | Zip Code          |  |
| Insured's Name     | Date of Birth          | Relationship     | Social Security # |  |
| Insured's Employer | Address/State/Zip Code |                  | Telephone #       |  |

## SECONDARY INSURANCE INFORMATION

|                    |                        |                  |                   |  |
|--------------------|------------------------|------------------|-------------------|--|
| Name of Company    |                        | Office Co-Pay \$ | Insurance Phone # |  |
| Group Number       |                        | Policy Number    |                   |  |
| Insurance Address  |                        | City/State       | Zip Code          |  |
| Insured's Name     | Date of Birth          | Relationship     | Social Security # |  |
| Insured's Employer | Address/State/Zip Code |                  | Telephone #       |  |

## PATIENT AUTHORIZATION

I authorize my insurance benefits to be paid directly to Dr. Farahmand and I am financially responsible for all charges. I hereby consent the release and re-disclosure of my medical record to enable or facilitate the collection, verification, or settlement of my account for any amounts due from me or any third party payer, health maintenance organization, insurer, or other health benefit plan.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*How did you hear about us?* Yellow Pages Physician Referral Service Website Family/Friend Insurance Company  
Direct Mail Magazine Newspaper