PATIENT INFORMATION

NAME _____ DATE OF BIRTH _____ AGE _____

HOME ADDRESS _____ CITY _____

ZIP _____ MALE _____ FEMALE _____ SOCIAL SECURITY #_____

HOME PHONE _____ SPOUSE _____

IN CASE OF EMERGENCY NOTIFY _____ PHONE _____

PRIMARY PHYSICIAN _____ PHONE _____

REFERRING PHYSICIAN _____ PHONE _____

EMPLOYER INFORMATION

EMPLOYER _____ ADDRESS _____

CITY _____ ZIP _____ WORK PHONE _____

OCCUPATION _____

PRIMARY INSURANCE

PRIMARY INSURANCE _____ GROUP NUMBER _____

ADDRESS _____ CITY _____ ZIP _____

NAME OF INSURED _____ DATE OF BIRTH _____

SOCIAL SECURITY #_____ RELATIONSHIP TO INSURED _____

SECONDARY INSURANCE

SECONDARY INSURANCE _____ GROUP NUMBER _____

ADDRESS _____ CITY _____ ZIP _____

NAME OF INSURED _____ DATE OF BIRTH _____

SOCIAL SECURITY #_____ RELATIONSHIP TO INSURED _____

I permit payment to Hisham El-Bayar, M.D. and/or Anita K. Gregory, M.D. any benefits due for their services rendered. I understand that I am financially responsible for charges not covered by my insurance company. Authorization is hereby granted for release of information to process my claim.

Authorized Signature _____ **Date** _____