PATIENT REGISTRATION INFORMATION

Date: _____ Phone: _____ Cell Ph. _____

Pt. Name: First _____Middle(Maiden)_____Last_____

Sex: F M Social Security # _____ Date of Birth _____

Mailing address:_____
Street City State Zip
Email Address: _____

Patient Occupation: _____ Status Married Single Widowed Divorced
(Please circle one)
Patient Employer/School:_____ Phone: _____
Address _____

In case of emergency, please notify: _____Phone:_____

Please list 2nd Contact: (Person not living with you) _____PH# _____

Address: _____

Insurance Information:

Primary Insurance - Company: _____

Address: _____
Street City State Zip
Identification No: _____Group No: _____

********** Policyholder's Name (If different from patient) _____

********** Policyholder's SS # _____Date of Birth _____

Policyholder's Employer:_____Phone _____

Address: _____
Street City State Zip

Is this visit for Worker=s Compensation? _____ Auto? _____Date of Accident: _____

Briefly, how did it happen? _____

I hereby authorize payment for my medical services to Hisham Hanai, MD/Mark A. Hardin, DO/Kyle Knabb, DO. If this physician is not a participating provider and/or is not listed as my PCP with my health insurance, I agree to be financially responsible for services rendered.

Signed:_____

I hereby authorize Hisham Hanai, MD/Mark A. Hardin, DO/Kyle Knabb, DO to release to my insurance company any information required for payment, including diagnosis information and records in the course of my examination and treatment.

Signed: _____