PATIENT REGISTRATION

NAME: _____
ADDRESS: _____
_____

DOB: _____/_____/_____
HOME PHONE# ( ) _____
WORK PHONE# ( ) _____ EXT _____
CELL PHONE# ( ) _____
SOCIAL SECURITY# _____

IN CASE OF EMERGENCY_____
RELATIONSHIP_____
PHONE# ( ) _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME:_____
NAME OF INSURED:_____SS#_____
ID#_____GROUP#_____

PHARMACY:_____
REFFERING PHYCIAN:_____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby assigns to Dr. Askari rendering service and authorized payment directly to him,

RELEASE OF MEDICAL RECORD INFORMATION

I authorized Dr. Askari to request medical records on my behalf from any facility that I have been treated in for the purpose of continuity of care.

SIGNATURE_____ DATE_____