Date: _____ (PLEASE PRINT) Home Phone: _____

Patient Information

Name _____ SSN # _____
Last Name First Name Middle Initial

Address _____ Cell Phone _____

City _____ State _____ Zip _____

Sex M □ F □ Age _____ Birthdate _____ □ Married □ Widowed □ Single □ Minor
□ Separated □ Divorced □ Partnered for ____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ SSN # _____

Address (if different from patient's)_____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____Contract # _____

Group # _____ Subscriber # _____Names of other dependents on this plan _____

Additional Insurance

Is patient covered by additional insurance? □ Yes □ No
Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient's)_____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____Contract # _____

Group # _____ Subscriber # _____Names of other dependents on this plan _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)

Assign directly to **Dr. Ahmed** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named physician may use my health care information any may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Guardian or Personal Representative Date

_____ _____
Please print name if Patient, Parent, Guardian or Personal Representative Relationship to Patient