PATIENT REGISTRATION FORM

Today's Date:_____

Patient Information

Patient Number:

First Name	Middle Name	Last Name	
Sex	Marital Status	Date of Birth	Social Security Number
Patient's Address	City	State	Zip
Home Phone	Cell Phone	Work Number	Ok to call at work?

Please indicate if it is okay for us to leave a confidential voice mail that may include test results, prescription information, or any other medical information pertaining to your health. This will reduce the need for you to return our call if you do not have any additional questions. This should be a phone number where only you, or anyone that you are comfortable with hearing your medical information, has access to.

Phone number that it is ok to leave message on	Initials_____	
Ethnicity	Race	Preferred Language
Occupation	Employer	How Did You Hear About Us?
Preferred Pharmacy	Pharmacy Cross Streets	Pharmacy Phone Number

How May We Contact You? Please Select All That Apply Mail ☐ Text ☐ Phone ☐ Email ☐

Email Address	Phone Number we can text to

Please send me an email invitation to register for the patient portal. The portal can be used to request appointments, for medication refill requests and for non emergent medical questions.

Initial_____

Parent/Guardian/Spouse

First Name	Middle Name	Last Name	
Sex	Marital Status	Date of Birth	Social Security Number
Address	City	State	Zip
Home Phone	Cell Phone	Work Number	Ok to call at work?

Primary Medical Insurance/Work Comp Insurance/Auto Insurance

Insurance Company Name	ID #	Group #
Street Address	City, State, Zip	Phone #
Name of Subscriber,(MUST HAVE name, SSN, DOB to bill)	Social Security #	Subscriber's Date of Birth

Work Comp and Auto Insurance Only Date of Accident: Claim's Adjuster Name:

Secondary Medical Insurance

Secondary Insurance Name ID# Group #

Street Address	City, State, Zip	Phone #
Name of Policy Holder	Social Security #	Date of Birth

Emergency Contact Information

Name	Relationship		Phone #
Address	City	State	Zip

AGREEMENT TO PAY FOR TREATMENT

I, the responsible party, hereby agree to pay all the charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization, with which this office had a contractual agreement, I agree to pay all applicable co-payments, co-insurance and deductibles, which arise during the course of treatment for the patient. The responsible party also agrees to pay for treatment rendered to the patient, which is not considered to be a covered service by my insurer and/or a third party insurer or other payer.

X _____

RESPONSIBLE PARTY DATE

RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO THE PROVIDER

I hereby authorize Abdul Dahhan, MD, and his employees to release and disclose, all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.

I, authorize the release and disclosure of any and all of my, or my child's, medical records to any other entity, including, but not limited to specialty physicians, hospitals, or other health care providers which may be of assistance in the opinion of this office, in providing treatment of the patient.

I, authorize the release of records necessary to assist in the reimbursement of benefits to which I may be entitled.

I, authorize this office and/or its employees to release, via fax or other secure electronic means, medical records which are needed in order to provide the patient with the most appropriate medical care.

I, authorize and request that payment of any third party or insurance company benefits be made directly to Abdul Dahhan, MD, for any services furnished to the patient. The signature furnished below shall suffice for all insurance forms on a continuing basis.

X _____

RESPONSIBLE PARTY DATE

CONSENT FOR TREATMENT

By signing below, I, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medical services, surgical or diagnostic procedures, including lab and radiographic studies, as ordered by this office and it's healthcare providers.

X _____

RESPONSIBLE PARTY DATE

***Patients with Health Plans, please present your insurance ID Card to the receptionist after completing this form.**

***Some contract Health Plans (HMO, PPO, IPA, etc) require a co-payment at the time of service-Please have this ready prior to your visit as well. As any current balance due. If copayor past due balance is not paid at the time of visit, patient may be required to reschedule the appointment.**