Patient Information

Name _____ Soc Sec # _____
Last Name First Name MI

Address_____ Apt #_____

City _____ State ____ Zip _____ Email address:_____

Home # (____)_____ Work _(____)_____ Cell# _(____)_____

M F Age ____ DOB ___/____/_____ Marital Status (please circle) S M W Sep Div Student

Employers Name _____ Occupation _____

Spouses Name _____ DOB ____/_____/_____ Spouse Retired Yes No

Spouses Employer _____ Spouse Employer Phone # (___)_____

In case of emergency, who should we notify? _____ Phone # (____)_____

You were referred by: Emergency Room Insurance Company Friend/Family Member Doctors Office

****PLEASE LIST YOUR REFERRING PHYSICIAN'S NAME:**_____

PRIMARY INSURANCE

Insurance Company _____ Policy # or Member ID _____

Policy Holder's Name _____ DOB ____/_____/_____
Last Name First Name MI

Relationship to Patient _____

SECONDARY INSURANCE

Do you or the patient have any other insurance? YES NO If yes, please list additional company _____

Policy # or Member ID _____

Subscriber to Account _____ DOB _____/_____/_____
Last Name First Name MI

Relationship to Patient _____

Please fill out all of the above information to the best of your ability so that we can provide you with the best service possible. If you have any questions feel free to approach one of our staff members, we are here to help you and answer any questions or concerns you might have.

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with the above named company(ies) and assign directly to Dr. Khosrow Seyed-Makki all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance company(ies). I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature Relationship (if minor) Date

OUR OFFICE DOES NOT ACCEPT CHECKS!

CO PAYMENT MUST BE PAID BEFORE SERVICES ARE RENDERED AND CAN NOT BE BILLED.

MEDICAL INSURANCE AND FINANCIAL ARRANGEMENTS

We are committed to providing you with the best care possible. In order to achieve that goal we need your assistance and your understanding of your payment policy.

Payment for office visits is due at the time services are rendered unless we are able to verify insurance eligibility and deductible status for the current year. If your deductible is met you are then responsible for the balance of charges of which your insurance company did not pay. Balances are to be paid in full upon receipt of statement from our office. If complete payment cannot be made please contact our office to make other arrangements.

[redacted] Initials _____

If your insurance requires you to have a referral to see a specialist it is your responsibility to obtain one for each office visit from your primary care physician. Most referrals can be written for up to 3 visits. It is our office policy that you will not be seen unless a valid referral is given to the receptionist for that day. Initials _____

We will gladly answer any questions relating to your medical insurance. You must realize however that

1. Your insurance plan is a contract between you, your employer (if applicable) and the insurance Company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most insurance Companies and therefore are covered up to the max allowance determined by each company.
3. Not all services are a covered benefit for all contracts, some insurance companies select certain services they will not cover. If you choose to have a service performed that is not covered you are responsible for payment of the entire charge.
4. If is your responsibility to notify our office and provide current insurance information.

We must emphasize that as a medical care provider our relationship is with you, not your insurance company(ies). While the filing of insurance claims is a courtesy that we extend to our patients all charges are your responsibility from the date services are rendered.

For Attorney claims you must furnish the name, address, phone #, and claim/case number for the insurance company or law firm you will be using. An "Assignment and Authorization" form that is provided to you by this office must accompany all attorney(s) cases and is to be signed by both you and your attorney(s). This office, prior to any release of medical records to your attorney, must also receive a written request for your records.

[redacted]

1. _____Please note that there is a fee for Release of Medical Records; fee must be received by our office prior to release of records. (20 pages)
2. [redacted]
3. [redacted]
4. [redacted]
5. _____ If you are being scheduled for surgery and have a deductible/co pay this must be paid by the pre op appointment.
6. _____There is a fee for filling out any forms (fee is based on extent of form and is set by the Doctor).

If you have any questions and/or uncertainty regarding any of the above please do not hesitate to ask our staff, we are here to help you.

Responsible Party Signature _____ Relationship (if minor) _____ Date _____

Dr. Khosrow Makki

Patient Name: _____DOB: ___/____/_____ Occupation:_____

MEDICAL HISTORY

Please Check All That You Are Currently Experiencing:

___Anemia
___Chest Pains
___Current use of Monoamine Oxidase Inhibitors for Depression
___Diabetes
___Drug or Alcohol Abuse
___Heart Disease
___Heart Rhythm Disturbances (Skipped or Rapid Heart Beats)
___High Blood Pressure
___HIV/AIDS
___Hormone Problems (i.e. Cushings Disease)
___Gastrointestinal or Liver Disease
___Glaucoma
___Kidney Disease
___Lung Disease (Emphysema, Asthma, TB)
___Menstrual Irregularities
___Nervous System Disease
___Pregnancy
___Prior use of Diet Medications
___Psychiatric Disorders (Depression, Psychosis)
___Smoke ____ Pack Per Day
___Thyroid Disease

Please List Any Of The Following:

*Allergies:*_____
_____

Surgeries:_____
_____

Recent Hospitalizations:
_____
_____

Medications:_____
_____

I have read and answered all questions accurately and to the best of my knowledge

_____

Responsible Party Signature Relationship (if minor) Date