1 Patient Information

Patient's Last Name | **First Name** | **Middle Initial**

Street Address | **Apt No.**

City | **State** | **Zip Code**

(Area Code) Home Phone Number

( )

Birth Date of Patient (Month/Day/Year) | **Sex**

❑ Male ❑ Female

Social Security Number

Marital Status

❑ Single ❑ Married/Partnership

Employment Status

❑ Employed ❑ Un-Employed ❑ Student ❑ Retired

Drivers Licence Number or State ID Number | **State**

2 Insurance Information

❑ **Have Insurance** ❑ **DO NOT Have Insurance**

Primary Insurance Company Name ❑ **Private** ❑ **Medicare** ❑ **Medi-CAL** ❑ **Managed Care**

Name of subscriber - exactly as printed on the insurance card

Patient's relationship to the insured | **Subscriber's Date of Birth**

❑ Self ❑ Spouse/Partner ❑ Child

Membership or Policy Number | **Group Num-**

Effective Date or Issue Date as printed on the card

Secondary Insurance Company Name ❑ **Private** ❑ **Medicare** ❑ **Medi-CAL** ❑ **Managed Care**

Name of subscriber - exactly as printed on the insurance card

Patient's relationship to the insured | **Subscriber's Date of Birth**

❑ Self ❑ Spouse/Partner ❑ Child

Membership or Policy Number | **Group Num-**

Effective Date or Issue Date as printed on the card

3 Employment Information

Employer's Business Name

Address

City | **State** | **Zip Code**

(Area Code) Work Phone Number | **Extension**

( )

Supervisor's Name (Last, First)

Employee's title, position | **Department**

4 Consent & Agreement

I/We hereby authorize Dr. Behrooz D. Soofer, associate doctors or staff deamed qualified to evaluate and treat the "patient" named on this form.

I/We further authorize the exchange of past, present and future medical information with the patient's other medical care givers for the purpose of enhancing and promoting the continuity of care for the patient.

If the "patient" is a minor, <18 years of age, I certify that I am the minor's parent, guardian or have legal custody of the "patient" and have the right to consent to the above.

I, the undersigned certify that I (or my dependent) have health and medical insurance and assign directly to Dr. Behrooz D. Soofer all insurance benefits, if any, otherwise payable to me for services rendered.

In Medicare assigned cases, the physician or supplier agrees to accept the charged determination of Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and discovered services.

I/We understand that not all services and fees are covered by insurance or government programs. I/We agree to be responsible for paying all deductbiles, co-payments and discovered services and any portion of charged services not paid in full by the insurance or government program.

Returned checks are charged $20. There is a flat $10/ month processing fee applied to your balance for charges remaining past due over 60 days.

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.

Beneficiary Signature
(if patient is under 18 then Parent, Guardian or other legally responsible party)

Date