PATIENT INFORMATION

NAME_____
FIRST **MI** **LAST**

ADDRESS_____ **APT#**_____ **CITY, ST, ZIP**_____

DATE OF BIRTH _____/_____/_____ **SS#**_____ **MALE**_____ **FEMALE**_____

PHONE NUMBER (_____**)**_____ **WORK NUMBER (**_____**)**_____

CELL PHONE #(_____**)**_____ **FAX # (**_____**)**_____ **E-MAIL**

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT_____

RELATIONSHIP TO PATIENT_____ **PHONE NUMBER(** **)**_____

PRIMARY INSURANCE INFORMATION

INSURED'S NAME_____ **DATE OF BIRTH**_____

SS#_____ **EMPLOYER**_____

INSURANCE CO NAME_____ **PHONE #**_____

ID#_____ **GROUP #**_____

OFFICE VISIT COPAY $_____ **DEDUCTIBLE $**_____

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

INSURANCE CO NAME_____ **PHONE#**_____

ID#_____ **GROUP #**_____

REFERRED BY:_____

EMERGENCY CONTACT NAME:_____ **RELATIONSHIP**_____ **PHONE#**_____

ASSIGNMENT OF BENEFITS

I hereby authorize Sid Danesh, MD to furnish information to insurance carriers concerning this illness. I hereby irrevocably assign to Sid Danesh, MD all payments for medical services rendered and all major medical benefits. I authorize Sid Danesh, MD to inquire and receive any information pertaining to my insurance company as a courtesy to me.

PATIENT/GUARDIAN SIGNATURE_____ **DATE**_____