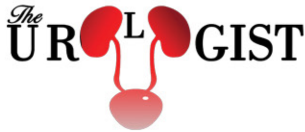

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REGISTRATION INFORMATION

DATE: ______________ **HOME PHONE:** ________________________ **CELL PHONE:** ______________________ **EMAIL:** _____________________________

PATIENT'S NAME: ____
LAST FIRST MI

STREET ADDRESS: ____

CITY: ____ **STATE:** _____________________ **ZIP:** _____________________

SEX:_____**M** _____**F** **AGE:** _______**Years** **BIRTH DATE:** _______/______/________ **SS#:** _____ _____ _____- _____ _____- _____ _____ _____ _____

HEIGHT: _______' ______" **WEIGHT:** ____________**Lbs** **MARITAL STATUS:** ______ **SINGLE** _______ **MARRIED** _______ **DIVORCED** _______ **OTHER**

OCCUPATION: ________________________________ **EMPLOYER:** ________________________________ **PHONE:** ___________________________

ADDRESS: _______________________________________ **CITY/ STATE:** ___________________________________ **ZIP:** _____________________

SPOUSE (OR RESPONSIBLE PARTY) NAME: ____ **EMPLOYED BY:** ____________________________

BIRTH DATE: _____________________ **SS#:** _____ _____ _____- _____ _____- _____ _____ _____ _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _______________________________________ **RELATIONSHIP TO PATIENT:** ____________________________

NAME OF PRIMARY INSURER: ____ **NAME OF SECONDARY INSURER:** __________________________________

NAME OF YOUR PRIMARY DOCTOR: _______________________________________**PHONE:** _________________________ **FAX:** ____________________

NAME OF YOUR DRUG STORE: ____ **PHONE:** _________________________ **FAX:** ____________________

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED?: ____

PHONE: ____________________________________ **RELATIONSHIP TO PATIENT:** ____________________________________

ASSIGNMENT AND RELEASE

I, THE UNDERSIGNED, HAVE INSURANCE COVERAGE WITH ____ AND ASSIGN DIRECTLY TO **DR. ARIF H. AGHA, M.D.**
NAME OF INSURANCE COMPANY
ALL MEDICAL 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 HEARBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY SUBMISSIONS WHETHER MANUAL OR ELECTRONIC.

X____ ________________________
SIGNATURE DATE

MEDICARE AUTHORIZATION

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO **DR. ARIF H. AGHA, M.D.,** FOR ANY SERVICES FURNISHED TO ME BY THAT PHYSICIAN. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZES RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. IF "OTHER HEALTH INSURANCE" IS INDICATED IN ITEM 9 OF THE HFCA-1500 FORM. OR ELSEWHERE ON OTHER APPROVED CLAIM FORMS OR ELECTRONICALLY SUBMITTED CLAIMS, MY SIGNATURE AUTHORIZES RELEASE OF THE INFORMATION TO THE INSURER OR AGENCY SHOWN. IN MEDICARE ASSIGNED CASES, THE PHYSICIAN OR SUPPLIER AGREES TO ACCEPT THE CHARGE DETERMINATION OF THE MEDICARE CARRIER AS THE FULL CHARGE, AND THE PATIENT IS RESPONSIBLE ONLY FOR THE DEDUCTIBLE, COINSURANCE, AND NON-COVERED SERVICES. COINSURANCE AND THE DEDUCTIBLE ARE BASED UPON THE CHARGE DETERMINATION OF THE MEDICARE CARRIER.

X____ ________________________
SIGNATURE DATE