

PATIENT INFORMATION
PLEASE PRINT

DATE _____ DATE OF BIRTH _____ MALE / FEMALE
MARITAL STATUS _____
FIRST NAME _____ MIDDLE INITIAL ___ LAST NAME _____
ADDRESS _____ CITY _____
STATE _____ ZIP CODE _____
PHONE NUMBER: _____ EMAIL: _____
CELL /WORK NUMBER: _____

OCCUPATION: _____
EMPLOYERS NAME: _____
EMPLOYERS PHONE NUMBER: _____
EMERGENCY CONTACT: _____
PHONE NUMBER: _____

INSURANCE INFORMATION
PRIMARY/SECONDARY

(YOU DO NOT HAVE TO FILL OUT INSURANCE IF IT IS IN YOUR NAME THANK YOU!)

PRIMARY INSURANCE

SUBSCRIBERS NAME: _____ DATE OF BIRTH: _____

SECONDARY INSURANCE

SUBSCRIBERS NAME : _____ DATE OF BIRTH: _____

ACCOUNT RESPONSIBILITY (IF MINOR CHILD)

NAME OF RESPONSIBLE PARTY _____

RELATIONSHIP TO PATIENT _____

ADDRESS _____ **CITY** _____

STATE _____ **ZIP CODE** _____ **PHONE** _____

PLEASE SIGN

I hereby authorize Dr. Watnick and Dr. Mohammadi to leave a message on my answering machine regarding my result or any other medical information pertaining to my medical care YES/NO

SIGN: _____ **DATE** _____

PHONE NUMBER: _____

INSURANCE AUTHORIZATION

I hereby authorize Dr. Watnick and Dr. Mohammadi to furnish my information to my insurance carries concerning my treatment and hereby assign to the physicians all payments for all medical services rendered to me or my dependants. I understand that I am responsible for any deductibles, co-pays or amounts not covered by my insurance and that it is my responsibility to know my insurance coverage from this day forward.

SIGNATURE: _____ **DATE:** _____

EFFECTIVE JUNE 1, 2007 A CHARGE WILL BE MADE FOR CANCELLATIONS WITH LESS THAN 24 HRS NOTICE!!!