REGISTRATION INFORMATION
PATIENT INFORMATION

Home Phone_____ EMAIL_____

Cell Phone_____ Work Phone:_____

Patient_____ _____
Last name First name Middle Initial

Reason for today's visit:_____

Street Address_____ Apt. or Ste#_____

City_____ State_____ Zip Code_____

Sex_____ Age_____ Birthdate_____ S.S.# _____ Marital Status: _____

Responsible party (**if a minor**)_____**Relationship to patient** _____

Patient's or Responsible Parent's employer _____Phone_____

Employer's address _____Phone_____

Spouse's Employer _____ Phone_____

Nearest relative or Emergency
Contact_____Phone_____

Primary Insurance Carrier with ID#_____

Primary Insurance address to submit claims_____

Secondary Insurance Carrier with ID#_____

IF COVERAGE IS PROVIDED THROUGH A SPOUSE OR PARENT, PLEASE GIVE PRIMARY MEMBER'S NAME S.S. # AND BIRTH DATE.

NAME:_____ RELATIONSHIP:_____ BD: _____

Effective date of insurance coverage:_____
We require a 48 hr cancellation, otherwise you will be charged $35.00 for 1st missed and $65 for second missed.

ASSIGNMENT OF INSURANCE BENEFITS

I authorize the release of any information relation to all claims for benefits submitted on behalf of myself and/or dependents. I agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered without obtaining my signature on every claim submitted for myself and/or dependents, and that I will be bound by this signature.

I_____authorize_____
(Print name) (name of insurance co.)
To pay and hereby assign directly to Mehdi Balakhani, M.D. all benefits, if any, otherwise payable to me for his services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Mehdi Balakhani, M.D. will be credited to my account, in accordance with the above said assignment.
X_____Date _____

Medical Information

You may use the back of this page when more space is needed to answer questions

Height_____ *Weight* _____

1. Have you had general anesthesia (asleep for a procedure)? Yes No

2. Did you experience any kind of problems? Yes No _____

3. Any family members with anesthesia problems? Yes No

Please give us a brief history of surgical procedures (date, type of procedure)

4. Have you had any recent hospitalizations that did not require anesthesia? Yes No

For what reason and DATES:

Current Medical Conditions: (Circle) If Yes Briefly explain next to answer

1. Heart trouble	Y N	11 Mitral Valve Prolapse	Y N
2. High blood pressure	Y N	12. Hepatitis or Jaundice	Y N
3. Respiratory problems	Y N	13. Kidney Problems	Y N
4. Asthma	Y N	14. Epilepsy or	Y N
5. Shortness of Breath	Y N	nervous condition	
6. Dental Disease	Y N	15. Psychological problems	Y N
7. Diabetes	Y N	16. Cancer	Y N
8. Bleeding disorders	Y N	17. Thyroid	Y N
9. MRSA (present or past)	Y N	18. Staph (present or past)	Y N
10. HIV	Y N		

5) Are you taking COUMADIN or any medications containing ASPIRIN? YES NO

6) Are you taking any other medications at present? YES NO

7) If yes, give name(s) of medication and reason:

8) Are you allergic to any medications if so list:

9) Have you taken any CORTISONE MEDICATION within the past year? YES NO

10) Do you have any of the following? Capped teeth- Root canal- Partial plates or dentures

11) Do you smoke? YES NO If yes how many cigarettes per day? _____

12) Are you currently under Hospice care? N Y If yes, Hospice care facility name_____Date started on Hospice_____.

Family Physician _____Phone_____

Address _____

How did you learn of our practice _____

AUTHORIZATION FOR MEDICAL TREATMENT

I hereby authorize any examination, including x-ray, photographs for educational purposes, laboratory test, and the applications of splints or casts, the administration of injections or aspirations by Dr. Balakhani, or his alternate assistant during the course of diagnosis and treatment.

Date_____Signature_____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Balakhani to release any information acquired in the course of my exam and/or treatment to my insurance company, family physician, or attorney if applicable.
Date_____Signature_____

Are there other procedures that you would be interested in now or in the future? Other member of your Family?

_____

OUR FINANCIAL POLICY

We are committed to providing you with the best possible care and we are willing to discuss our services with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your responsibility.

INFORMATION

Prior to receiving service, you must complete our Patient Registration form and any medical information forms and provide your insurance card(s) for photocopying.

INSURANCE

Insurance is a contract between you and your insurance company. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, "usual and customary" charges, etc., other than to supply factual information as necessary. You are responsible for the timely payment of your account.

Medicare- We are a participating provider and will, if you provide the information, bill any balance to your secondary insurance. You will be responsible for any deductible or co-insurance you secondary carrier does not cover.

HMO Plans- You must provide proper authorization from your primary care physician prior to receiving service. If authorization has not been obtained, it will be necessary to reschedule your appointment.

Self-pay- If you do not have insurance, payment, in full is expected at the time of service. We also are associated with a patient financing program surgical procedures; please ask us for more information about this service. We accept **cash, checks, money orders, and Visa/Master Card.**
I have read the above policy and understand my responsibility for my account.

X Signature_____ Date:_____