REGISTRATION INFORMATION
PATIENT INFORMATION

Home Phone_____ Email: _____*For communication

Cell Phone_____ Work Phone:_____

Patient_____ _____
Last name First name Middle Initial

Reason for today's visit:_____

How did you learn of our practice _____

Street Address_____ Apt. or Ste#_____

City_____ State_____ Zip Code_____

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

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

Occupation:_____ Employer: _____

Employer's address _____Phone_____

Spouse's Employer _____Phone_____

Nearest relative or Emergency
Contact_____Phone_____Relation to patient:_____

Primary Insurance Carrier with ID#_____

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:_____ Birthdate: _____

Effective date of insurance coverage:_____

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 Signature _____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 _____

**** **Please give a brief history of ANY surgical procedures including where procedure was performed:**

3. Any family members with anesthesia problems? Yes No

4. Have you had any recent hospitalizations? Yes No

For what reason and DATES:

Circle Current Medical Conditions: 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		
ANY HEALTH CONDITIONS NOT LISTED?			

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

6) Do you have a Cardiologist? YES NO If yes, Physician's name:

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

8) If yes, give name(s) of medication and what the medication is for:

9) Are you allergic to any medications if so list:_____

10) Have you taken any CORTISONE MEDICATION within the past year? Y N
11) Do you smoke/Vape? YES NO If yes how often per day? _____
12) Marijuana use: YES NO Frequency:_____
13) Illicit Drug use: YES NO _____
14) Are you currently under Hospice care? If yes, Hospice care facility name:_____

Date started on Hospice_____.

Family Physician _____**Phone**_____

Address _____

If we need to disclose or ask for any information, who may we have your permission to contact?

Name:_____ **Phone#**_____ **Relationship**_____

AUTHORIZATION FOR MEDICAL TREATMENT & AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any examination, including x-ray, photographs for 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. 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.

X Signature_____**Date**_____

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 your 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. If seen without an insurance referral You will be responsible for the charge(s).

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/Discover/Amex/Care Credit**

I have read the above policy and understand my responsibility for my account.

X Signature_____ **Date:**_____