

Personal & Financial Information Form

PATIENT INFORMATION (please print legibly)

Last Name	First	MI	Home Phone	Cell Phone
_____ (____) _____ (____) _____				
Address _____				

City	State		Zip	

Mailing Address (if different) _____				

Patient's Date of Birth	Age	Sex	Marital Status	
_____	_____	M _____ F _____	M _____ S _____ W _____ D _____	
Patient's Social Security Number		Drivers License Number		
_____		_____		
Patient's Employer		Occupation		
_____		_____		
Employer Address		Work Telephone Number		
_____		_____ (____) _____		
Spouse's Name		Spouse's Employer	Work Telephone Number	
_____		_____	_____ (____) _____	
Emergency Contact (local relative or friend)	Relationship	Telephone No.		
_____	_____	_____ (____) _____		
Alternate Contact (not living at same address)	Relationship	Telephone No.		
_____	_____	_____ (____) _____		
Referred to this office by:				
Friend	Doctor	Ad	Other	
_____	_____	_____	_____	

PLEASE LIST ALL YOUR CURRENT INSURANCE CARRIERS

Primary Insurance Company	Policy Number	Group Number	
_____	_____	_____	
Subscriber Name	Relationship to Patient	DOB	Social Security No.
_____	_____	_____	_____
Secondary Insurance Company	Policy Number	Group Number	
_____	_____	_____	
Subscriber Name	Relationship to Patient	DOB	Social Security No.
_____	_____	_____	_____

FINANCIAL RESPONSIBILITY

I understand that I am responsible for payment of all medical/surgical services rendered to me and/or my dependents regardless of whether or not I have medical insurance. I hereby, authorize payment of my insurance benefits directly to Dr. Ali Lashgari for any medical/surgical services rendered to me and/or my dependents that are not paid directly by me. I further agree that a photocopy of this agreement shall be as valid as the original and also authorize Dr. Ali Lashgari to release any and all information necessary concerning my diagnosis and treatment for the purpose of securing payment from my insurance carrier(s).

Signature _____ Date _____