PATIENT INFORMATION FORM

PATIENT NAME _____ CHART # _____

SEX _____ AGE _____ BIRTHDATE _____ SS# _____

MARITAL STATUS: SINGLE_____ MARRIED _____ WIDOWED _____ DIVORCED_____SEPARATED ____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

PHONE _____ ALTERNATE/CELL PHONE _____

MAILING ADDRESS _____

PATIENT'S EMPLOYER _____ PHONE _____

EMPLOYER ADDRESS _____

PERSON RESPONSIBLE FOR BILL _____ SS# _____

SPOUSE'S NAME _____ BIRTHDATE _____ SS# _____

SPOUSE'S EMPLOYER _____ PHONE _____

NOTIFY IN CASE OF EMERGENCY _____

RELATIONSHIP _____ PHONE _____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER _____ POLICY# _____

ADDRESS _____ ID# _____

SECONDARY INSURANCE CARRIER _____ POLICY# _____

ADDRESS _____ ID# _____

REFERRING PHYSICIAN _____ PRIMARY PHYSICIAN_____

CONSENT AND AUTHORIZATION

THE UNDESIGNED HEREBY AUTHORIZES MOHAMED S. MEGAHY PH.D.M.D. AND /OR O. DEAN NORTON, M.D., TO EXAMINE AND PROVIDE MEDICAL CARE AND TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM, OR TO PROVIDE MEDICAL INFORMAITON TO OTHER PHYSICIANS OR MEDICAL FACILITIES AS REQUESTED. I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO MOHAMED S. MEGAHY PH.M.D. AND FULLY UNDERSTAND THAT I AM DIRECTLY RESPONSIBLE FOR ALL MEDICAL BILLS AND IF NECESSARY REASONABLE ATTORNEY FEES AND LEGAL COST TO COLLECT SAID PROFESSIONAL FEES DUE TO MOHAMED S. MEGAHY, PH.M.D., FOR MEDICAL SERVICES RENDERED ME.

SIGNATURE _____ DATE _____