CONFIDENTIAL

Patient Name: _____ Age: _____ Birth Date: _____/_____/_____
Sex: M F **Marital Status:** S M W D

Address:_____City:_____State:_____Zip:_____

Patient's Social Security #:_____/____/_____ Home Telephone #: (_____) _____-_____
Employer: _____ Work Telephone #: (_____) _____-_____
Occupation:_____ Cell Number: (_____) _____-_____

Spouse/Guardian Name: _____Employer:_____ Occupation_____
Phone #:(_____) _____-_____ SS#_____/_____/_____ Date of Birth: _____/_____/_____

MEDICAL INFORMATION

Referred by: _____Family Doctor:_____ Phone: (___) ____-_____
What is your Chief Complaint? _____
When did these symptoms start? _____
List any medications you currently take: _____
Any previous operations? (*list*) _____
Allergies? (*list*) _____

HEALTH INSURANCE INFORMATION

PRIMARY:
Name of Co. _____
Address: _____
_____
ID# _____Group #_____
Subscriber: _____
Subscriber:_____
Relation to patient: _____

SECONDARY:
Name of Co. _____
Address: _____
_____
ID#_____ Group #_____
Relation to patient: _____

Is this injury due to (*check one*): **( ) Auto Accident** **( ) Workers Compensation**

Insurance Co.: _____
Address: _____
_____
Telephone #: _____
Adjuster: _____

Date of Accident: _____
Policy #: _____
Claim #: _____
Policy Holder Name: _____

If you have an attorney, please provide name, address and phone #:_____
_____

PLEASE READ AND SIGN THE FOLLOWING:

I hereby authorize any examination including x-rays and laboratory tests, the application of splints or casts, and the administration of injections or aspirations by Dr. Ali Kalamchi, M.D. or whomever he may designate as his alternates or assistants during the course of diagnosis and treatment.

I accept full responsibility for payment of this bill and hereby authorize payment directly to Ali Kalamchi, M.D., P.A. for the surgical and/or medical benefits, if any; otherwise payable to me for services rendered based on the usual charges for these services. I understand that I am financially responsible for any balance or charges not covered by my insurance.

I also hereby authorize Ali Kalamchi, M.D. to furnish information to the insurance company (s) concerning my illness and injury.

Date: _____ **Signature:** _____
(If a minor, parent's signature is required)