REGISTRATION AND CONSENT

DR SAYERA HAQUE
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PATIENT'S INFORMATION:

NAME: …….. …….. …….

LAST FIRST MIDDLE

DATE OF BIRTH: ...../...../..... SSN: ……..

MARRITAL STATUS: SINGLE/MARRIED/DIVORCED/WIDOWED SEX: MALE/FEMALE

EMPLOYMENT: FULL TIME/PART TIME/RETIRED/UNEMPLOYED/STUDENT/ OTHER: .....

EDUCATION: PRIMARY/MIDDLE SCHOOL/HIGH SCHOOL/SOME COLLEGE/BACHELOR/OTHER: .....

ADDRESS: STREET ..... APT .....

CITY: ..... STATE: ..... ZIP .....

CELL PHONE: …… HOME PHONE: ……

EMAIL: ……

LIVING WITH PATIENT: SPOUSE/PARENT/CHILD/OTHER: .....

NAME: …….. CELL: ……

EMERGENCY CONTACT NAME: ..... RELATION: ……

PHONE: ..... ADDRESS: ……

NEXT OF KIN NAME: …….. RELATION: ……

PHONE: …… ADDRESS: ……

PHARMACY NAME: ..... PHARMACY PHONE: .....

PHARMACY ADDRESS: .....

INSURED'S INFORMATION: NAME**:……..…D.O.B……..**

FIRST INSURANCE: NAME: …… ID: ……

RELATIONSHIP: SELF/SPOUSE/CHILD/OTHER: .....

NAME: …… DOB: ……

ADDRESS: STREET .....APT .....

CITY: ..... STATE: ..... ZIP .....

PHONE: HOME: ..... CELL: …… ……

SECOND INSURANCE: NAME: …… ID: ……

RELATIONSHIP: SELF/SPOUSE/CHILD/OTHER: .....

NAME: …… DOB: ……..

ADDRESS: STREET ..... APT .....

CITY: .....STATE…..... ZIP .....

I certify that the provided information is correct, and I authorize the doctor's office to use them for submission of all claims related to their services. I also authorize the use of this signature on all insurance submissions in default as if they are original signature to release medical documents to relevant insurance co or to any entity required by law. I allow this office to receive or collect all payments from the insurance company or other entity in part of full. If insurance doesn't cover any bill, I am responsible for any costs incurred. I consent the physician(s) and other health care staff(s) to render appropriate medical care to me/my dependent including such care as administration of meds/injections/tests as deemed necessary in the ambulatory care setting. The extent possible of the benefit/risk/complications (s)/side effects & alternative of such treatment was explained. I was not given any guarantee of success or outcome of such treatment/ intervention in a positive or negative way.

..... self/parent/guardian ……../……../.....

Signature of patient/responsible party Relation Date