

Patient Information

Name: _____ Middle: _____ Last: _____

Birth Name: _____ (at the hospital)

Address: _____ City: _____ State: _____ Zip: _____

Sex: M / F Age: _____ DOB: ____/____/____

How did you find out about us? _____

Siblings Names: _____

Primary Guarantor Information & Insurance

(Please provide your ID card with this information)

Name of Insured _____ Middle: _____ Last: _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: M / F DOB: ____/____/____ Marital Status: _____ Relationship to Patient: _____

Employer: _____ Phone: _____

Work: _____ Mobile: _____ Email: _____

Insurance Company: _____

Insurance Company Address: _____ City: _____ State: _____ Zip: _____

Subscribers I.D. #: _____ Group #: _____

Insurance Company Phone Number: _____

Credit Card Info. To be on file:

Credit Card #: _____ Type; Visa / Master card/ American Express

Name on the card; _____ Address & zip code: _____

Exp. Date: ____/____

Parent / Guardian Information

Parent / Guardian #1: (If different than Guarantor Information) Relationship to Patient: _____

Name: _____ Middle: _____ Last: _____ Suffix: _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: M / F DOB: ____/____/____ Marital Status: _____

Relationship to Patient: _____ Employer: _____

Phone: _____ Work: _____

Mobile: _____ Email: _____

Emergency Contact

Name: _____ Middle: _____ Last: _____
Address: _____ City: _____ State: _____ Zip: _____
Is above Emergency contact a Parent / Guardian? Yes / No Sex: M / F
Phone: _____ Work: _____
Mobile: _____ Email: _____

Assignment and Release

I hereby authorize payment directly to Dr. Iman Bar, for all insurance benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance within 60 days, and for all services rendered on my behalf or my dependents. I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature for payment and on all insurance submissions.

Signature of Responsible Party: _____ Date: _____

Print: _____