PATIENT REGISTRATION FORM

Date of Birth____________________

SS#________________________________

Patients
Name____

Address______________________________________

____

Home Phone________________________

Married, Divorced, Separated, Single (circle one)

Male __ Female__ (check one)

Patients
Employer___________________________________

Address______________________________________

____

Occupation___________________________________

Phone_______________________

Spouse's
Name_______________________________________

Spouse's Employer____________________________

Address______________________________________

_________________________Phone______________

Person Financially Responsible For This Account (circle one) Self Spouse Parent Other

Persons
Name____________________________________

D.O.B.______________SS#__________________

Primary Insurance
Company________________________________

Policy#___________________Group#__________

Secoundary Ins.
Company__________________________________

If Your Injury/Complaint Is The Result Of An Accident, Please Complete The Appropraite Information
Is this injury job related______or as a result of an Auto Accident_____.

Insurance Carrier:

____

Address__________________________________

____

Phone____________________

Name of Contact Person or Adjuser at Insurance Co.:

____

Date of Accident__________

Claim#__________________________________

I acknowledge receipt of Dr. Tariq Siddiqi's **"NOTICE OF PRIVACY PRACTICES"** for Protected Health Information.

Signed (Patient or Parent if Minor) ____ Date:________________

I authorize and request payment of my medical benefits directly to Dr. Tariq S. Siddiqi M.D., I understand that I am financially responsible for all charges for services to me, including the balance remaining after possible insurance benefits and I authorize the release of any medical information required to process this claim.

Signed (Patient or Parent if Minor)____ Date:________________

I request that payment of authorized **Medicare** benefits be made either to me or on my behalf to Dr. Tariq S. Siddiqi, M.D., for any services furnished me by Dr. Siddiqi's office. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Signed (Patient or Parent if Minor):____ Date:________________

PATIENT HEALTH HISTORY

Name:______________________________ **Age:**_____ **Date:**__________

Chief Complaint: (eg., headaches, back, neck, arm, leg, or hand pain etc.)

____

How long have you been experiencing this pain ?_________________

Are you a smoker?_______if yes, how many pack(s) per day?______

Do you use alcohol?_______

Do you use illicit drugs?_______

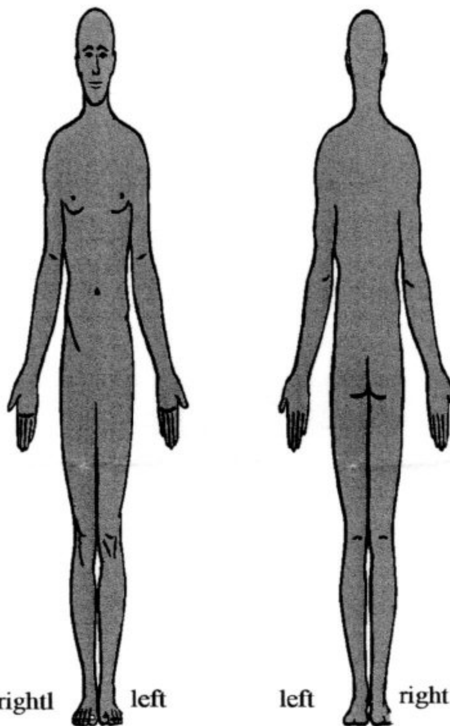
Are you currently out of work or on a light duty status for this condition ? If yes please explain.___________

How have you had to alter your life style due to your condition. (ie: housework, sports etc.)

____

Is there any litigation as a result of this medical problem.(eg.: Motor Vehicle, Workmens compensation law suit.)______________________

Have you ever been involved in a law suit against a healthcare provider ? __________



Please mark location of pain ! On a scale of 1-10 how severe is your pain?________

FAMILY DOCTOR: name, address, phone and fax.

____

If you have another doctor and would like a copy of the office reports mailed, please supply, the name and address below.

____

Pharmacy phone number:

____

ALLERGIES: (eg:Shellfish,dyes, Medications)

____

Existing Medical Conditions: (List **any** condition you are seeing a physician for.)

____

List all medication you are taking:

____

Family medical history:

____

Past medical history: (eg.,operations, hospitalizations)

____

Patient Height:____________

Patient Weight:____________