

## PATIENT REGISTRATION FORM

Date of Birth \_\_\_\_\_

SS# \_\_\_\_\_

Patients Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Married, Divorced, Separated, Single (circle one)

Male \_\_ Female\_\_ (check one)

Patients Employer \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Occupation \_\_\_\_\_

Phone \_\_\_\_\_

Spouse / Emergency Contact Name: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Spouse's Employer( If applicable for Ins. Information)

\_\_\_\_\_

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

Persons Name \_\_\_\_\_

D.O.B. \_\_\_\_\_ SS# \_\_\_\_\_

**Primary Insurance**

Company \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_

**Secondary Ins.**

Company \_\_\_\_\_

ID# \_\_\_\_\_

**\*If Your Injury/Complaint Is The Result Of An Accident,  
Please Complete The Appropriate Information\***

**\*\*Is this injury job related** \_\_\_\_\_

**\*\*Auto Accident** \_\_\_\_\_.

**\*\*The State the accident or injury occurred in:** \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_

Address \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Name of Contact Person or Adjuster 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 Guardian) \_\_\_\_\_ 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 Guardian) \_\_\_\_\_ 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 Guardian): \_\_\_\_\_ Date: \_\_\_\_\_