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 Guardain)_____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:_____