PATIENT DEMOGRAPHIC/ REGISTRATION SHEET

Allergy Sinus & Arthritis Clinic, PLLC

LAST NAME: _____ **FIRST NAME:** _____ **MI:** _____
Sex: _____ DOB: _____ Age: _____ Marital Status S M D SEP W
Address: _____
City, State, ZIP: _____ Home Phone: (__) _____
Work Phone: (__) _____ Cell Phone: (__) _____
Email: _____ SS #: _____ Driver License #: _____
Employer: _____ Occupation: _____
Medication Allergies: _____
Spouse Name ( ) OR Emergency Contact ( ) if not married: _____
Occupation: _____ Phone #: (__) _____

INSURANCE INFORMATION
Insurance Company: _____ HMO: _____ PPO: _____
Mailing Address: _____ Phone #: (__) _____
Policy #: _____ Group #: _____
Copay: _____ Deductible: _____ Referral Required: Yes No
Referring Physician: _____
Address: _____ Phone: _____

INSURED'S INFORMATION
Insured's Name: _____ Relation to PT: _____
Address: _____ Home Phone: (__) _____
City, State, ZIP: _____ Work Phone: (__) _____
SS #: _____ DOB: _____ Employer: _____

SECONDARY INSURANCE
Do you have other insurance coverage? Yes No
Insured's Name: _____ Relation to the patient: _____
Insurance Company: _____ Phone: ( ) _____
Policy #: _____ Group #: _____ DOB: _____

Minor Patient's Mother's Name: _____ Phone: (__) _____
Minor Patient Father's Name: _____ Phone: (__) _____

I authorize Dr. Muhammad Imran to release medical records to insurance for payment and for services and to the referring physician or primary care physician or other health care providers. I authorize and assign insurance benefits to Muhammad Imran M.D. for services rendered. I am responsible for all deductibles, co-insurances, co-pays and referrals when needed.

Signature: _____ Date: _____
Minor's Name: _____
I certify that I (print name) _____ am the parent or legal guardian of the above named minor.
Parent/ Guardian Signature: _____ Date: _____