Preferred Women Health Care, LLC

240 Williamson Street, Suite 405 Elizabeth, NJ Phone: (908) 353-5551

NEW PATIENT INFORMATION

Kamran Khazai , M.D.

DATE_____ REFERRED BY _____

PATIENT

PATIENT'S NAME (NOMBRE)

_____
(Last/Apellido)

_____
(First/Nombre) (Middle)

ADDRESS_____ APT# _____
(DIRECCION)

CITY _____
(Ciudad)

STATE_____ ZIP CODE_____
(Estado) (Zona)

HOME PHONE # _____
(Telephone)

BIRTHDATE_____ AGE_____
(Fecha de Nacimiento) (Edad)

SEX _____ SS # _____
(Sexo) (Seguro Social)

EMPLOYER _____
(Empleo)

ADDRESS _____
(DIRECCION)

OCCUPATION _____
(Ocupacion)

MARITAL STATUS _____
(Estado Civil)

BUSINESS PHONE # _____
(Telephone del Negocio)

EMAIL : _____

RESPONSIBILITY

RESPONSIBLE PARTY _____ RELATIONSHIP _____
(Persona Responsible) (Spouse if Applicable) (Relacion de Parentesco)

ADDRESS_____ APT# _____ CITY_____
(DIRECCION) (Ciudad)

STATE_____ ZIP CODE_____ HOME PHONE # _____
(Estado) (Zona) (Telephone)

EMPLOYER_____ OCCUPATION_____
(Empleo) (Ocupacion)

INSURANCE

IF A CLAIM IS TO BE SUBMITTED TO YOUR INSURANCE COMPANY, PLEASE COMPLETE THE FOLLOWING:

PRIMARY INS. NAME_____
(Seguro/ Aseguranza Proncipal)

ADDRESS_____
(DIRECCION)

INSURED_____
(Nombre de identificacion del Seguro)

BIRTHDATE_____ SS # _____
(Fecha de Nacimiento) (Seguro Social)

INSURED ID # _____
(Numero de identificacion del Seguro)

GROUP #_____
(Numero del Grupo)

SECONDARY INS. NAME_____
(Seguro Secundario/Aseguranza Secundaria)

ADDRESS_____
(DIRECCION)

INSURED_____
(Nombre de identificacion del Seguro)

BIRTHDATE _____ SS # _____
(Fecha de Nacimiento) (Seguro Social)

INSURED ID # _____
(Numero de identificacion del Seguro)

GROUP #_____
(Numero del Grupo)

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE MANAGER.

INSURANCE AUTHORIZATION AND ASSIGNMENT

ASSIGNMENT: I HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE UNDERSIGNED PHYSICIAN/UROLOGY ASSOCIATES. I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES.

RELEASE: I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE TO THE UNDERSIGNED PHYSICIAN AND AUTHORIZES RELEASE OF PROTECTED HEALTH INFORMATION TO THE INSURER OR HEALTHCARE CLEARINGHOUSE NECESSARY TO PAY CLAIM.

SIGNATURE _____ DATE_____