

Today's Date ___/___/___

Barazanji Family Medical Clinic

Barazanji/Brewer/Nayeri

Patient Information Please Print Clearly

Patient Name: _____ Date of Birth: ___/___/___
Last Name First Name MI

Address: _____ Sex: ___ Age: ___
Street City Zip

Social Security No: _____/_____/_____ Marital Status: (S M W D Sep) Please Circle

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Employer: _____ Are you a student? Full-Time or Part-Time
(please circle)

Address: _____ Work Phone: (_____) _____ - _____

Person(s) Financially Responsible – IF THE SAME AS ABOVE – SKIP THIS SECTION

Patient Name: _____ Date of Birth: ___/___/___
Last Name First Name MI

Address: _____ Sex: ___ Age: ___
Street City Zip

Social Security No: _____/_____/_____ Marital Status: (S M W D Sep) Please Circle

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Employer: _____ Are you a student? Full-Time or Part-Time
(please circle)

Address: _____ Work Phone: (_____) _____ - _____

Insurance Information – This information must be completed even if we have a copy of your insurance card

Primary Insurance

Name of Insurance Company: _____ Address: _____

Subscriber Name: _____ Employer: _____

Social Security No: ___/___/___ Date of Birth: ___/___/___ Relationship to Patient: _____

Group No: _____ ID No: _____ Effective Date: ___/___/___

Secondary Insurance

Name of Insurance Company: _____ Address: _____

Subscriber Name: _____ Employer: _____

Social Security No: ___/___/___ Date of Birth: ___/___/___ Relationship to Patient: _____

Group No: _____ ID No: _____ Effective Date: ___/___/___

Emergency Contact Information

Who may we contact in case of an emergency? _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Home Phone: (_____) _____ - _____

For Financial Responsibility and Assignment of Benefits

I understand that I am financially responsible to pay Barazanji Family Medcial Clinic, Brewer Family Medical Clinic, and/or Nayeri Family Medical Clinic its usual charges for all services received through the above mentioned clinics including any balances not covered by my insurance carrier(s). I hereby assign all of my rights to receive and all insurance proceeds, otherwise payable to me, for coverage(s) provided by my health insurance carrier(s) to Barazanji Family Medical Clinic, Brewer Family Medical Clinic, and/or Nayeri Family Medical Clinic and direct that payment of proceeds be made directly to the above mentioned clinics.

I UNDERSTAND THAT THE ULTIMATE RESPONSIBILITY AND FINANCIAL OBLIGATION FOR THE SERVICES RENDERED BY BARAZANJI FAMILY MEDICAL CLINIC, BREWER FAMILY MEDICAL CLINIC, AND/OR NAYERI FAMILY MEDICAL CLINIC ARE MINE.

Records Release for Claims Payment

I authorize the release of medical record information or excerpt thereof to any insurance company or third party payer for utilization management audit purposes and/or the purpose of verifying the services rendered and obtaining payment of the account. I understand that execution of this authorization waivers my right of confidentiality as the material release pursuant to the authorization.

My signature below represents that I have read and understand the terms and statements above.

Parent/Legal Guardian Signature:

Date: _____