Ahsan U. Rashid, M.D., F.A.C.P.
113 Waterworks Way Suite #250
Phone: (949) 753-1522 Fax: (949) 753-6075

PATIENT INFORMATION

First Name: _____ Last Name: _____ MI: _____

Home Address:		
City:	State:	Zip:

Home: _____ Cell: _____ Work: _____

Date of Birth: _____

E-Mail:_____ Driver's License #:_____

Employer: _____ Occupation: _____

Gender

○ Male
○ Female

Marital Status

○ Single
○ Married
○ Divorced
○ Separated
○ Widowed

Emergency Contact:

Relationship:	Phone:

Insurance Information:

IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE PROVIDE DATE OF BIRTH FOR CLAIMS

Insured Name:	
Insurance Company:	
Certificate # or Member #:	Group #:
Insurance Address:	
City:	State: Zip Code:

I hereby authorized Dr. Ahsan Rashid to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance and payment is due upon date of service unless other arrangements have been made.

Signature:	Date:

ALLERGIES:_____

MEDICATIONS

PRESCRIPTION	DOSAGE	FREQUENCY

MEDICAL PROBLEMS OR CONDITIONS

1.

2.

3.

FAMILY HISTORY

ANY FAMILY HISTORY OF MEDICAL PROBLEMS OR ILLNESS?

-
-
-
-

PAST SURGICAL HISTORY

1.

2.

3.

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS INFORMATION RELEASE AND CONSENT TO TREATMENT

I, the undersigned, authorized payment of medical benefits to Dr. Ahsan Rashid for any services furnished to me by the physician. I understand that I am financially responsible to any amount not covered by my contract. I also authorize you to release my insurance company information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluation and administering claims of benefits.

I, knowing that I have a condition requiring diagnosis, treatment, or related medical care do hereby consent to such care. Medical examination(s), operation(s), and/or treatment by my attending physician(s), their assistant(s), as may be necessary in their professional judgment. I further acknowledge that no guarantees have been made to me as to the result of such care, medical examination(s), procedure(s) and/or treatment.

Signed:_____

Date:_____

Ahsan U. Rashid, M.D.
113 Waterworks Way #250
Irvine, CA. 92618
(949)753-1522
(949)753-6075

NOTICE OF PRIVACY PRACTICE RECEIPT

This notice describes how medical/protected health information about you may be used and disclosed and how you can get access to this information.

We want to assure you that your medical/protected health information is secure with us.

This notice contains information about how we will insure that your information remains private.

As a patient you:

1. Can inspect and copy your information.
2. Can request corrections to your information.
3. Can request that your information be restricted
4. Can request confidential communication.
5. Can obtain a paper copy of this notice.

If you have a question about this notice, please feel free to contact our office listed below.

I acknowledge that I was provided with the Notice of Privacy Practices for Dr. Ahsan U. Rashid.

Print Name:_____

Signed Name:_____

Date:_____

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