LAMIA KADIR, M.D. PA

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PATIENT REGISTRATION FORM

Today's Date:

PATIENT INFORMATION

Patient's Last Name:	First:	MI:	DOB: / /	Age:	Marital Status (circle one): S / M / D / Sep / Widow

Sex: ❑ M ❑ F	Social Security #:

Street Address:	Home Phone:	Cell Phone:
	Email:	

City:	State:	Zip Code:

Occupation:	Employer:	Work Phone:

Chose clinic because/Referred to clinic by:

Other family members/friends seen here:

INSURANCE INFORMATION

(Please give your Insurance Card and Driver's License to the Receptionist)

Insurance Company:	Policy #:	Group #:	Phone #:
Subscriber's name:	Subscriber's Social Security #:		Subscriber's DOB:
Employer: Address:			Employer phone #:

Patient's relationship to subscriber:
❑ Self
❑ Spouse
❑ Child
❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Policy #:	Group #:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative (not living with you):	Relationship to you:	Home Phone #	Work Phone #

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize LAMIA KADIR, M.D. PA to release any information required to process my claims.

Patient Signature: X *Date: X*

FOR OFFICE USE ONLY: