

# Arezo Amirikia M.D., P.C.

## Patient Registration

### PATIENT INFORMATION

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_  
Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ Sex: M F  
Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Referred by: \_\_\_\_\_ Email \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

### PHARMACY INFORMATION

Please provide any information you may know about your pharmacy (local or mail order).

Name of Pharmacy \_\_\_\_\_  
Cross Roads \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Please Check:  30 day supply  90 day supply

### EMERGENCY CONTACT

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### PRIMARY MEDICAL INSURANCE

Please Check:  Medicare  BCBS  Blue Care Network  Priority Health  
 HAP  PPOM/Cofinity  United Health Care  Military  
 Self Pay  Other \_\_\_\_\_  
Subscriber Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Subscriber SS# \_\_\_\_\_ Subscriber Birth Date \_\_\_\_\_ Sex: M F  
Subscriber Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Employer Phone \_\_\_\_\_  
Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### SECONDARY MEDICAL INSURANCE

Please Check:  Medicare  BCBS  Blue Care Network  Priority Health  
 HAP  PPOM/Cofinity  United Health Care  Military  
 Self Pay  Other \_\_\_\_\_  
Subscriber Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Subscriber SS# \_\_\_\_\_ Subscriber Birth Date \_\_\_\_\_ Sex: M F  
Subscriber Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Employer Phone \_\_\_\_\_  
Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

(Please continue on back)

### VISION INSURANCE

Please Check:  BCBS Vision       VSP       Eyemed       Optum Health Vision (Spectera)  
 NVA       Heritage       Delta Vision       Superior Vision  
 MEBS       MECA       Other \_\_\_\_\_

**I do not have any vision insurance. I understand that I will be financially responsible on the day of service for any vision services/products received. Please initial \_\_\_\_\_**

Subscriber Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Subscriber SS# \_\_\_\_\_ Subscriber Birth Date \_\_\_\_\_ Sex: M      F  
Subscriber Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Employer Phone \_\_\_\_\_

**WORKERS COMPENSATION (Please Complete if Applicable)**

Date of Injury \_\_\_\_\_  
Business Name \_\_\_\_\_ Business Phone \_\_\_\_\_  
Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**AUTHORIZATION TO DISCUSS MY MEDICAL RECORDS**

Please list any person(s) you wish to permit access to your protected medical information.

I authorize \_\_\_\_\_,  
relationship to me \_\_\_\_\_, to discuss my medical condition with Dr. Arezo Amirikia or  
Dr. David Gourwitz or their designee and to obtain any test results on my behalf.

**AUTHORIZATION FOR TREATMENT AND BILLING**

I hereby authorize Arezo Amirikia, M.D., P.C., and its physicians, to treat me (or my dependent child) and to release any medical information required by my insurance carrier. If Arezo Amirikia, M.D., P.C. and its physicians participate with my insurance carrier, I authorize and request my insurance carrier to pay directly to Arezo Amirikia, M.D., P.C. for medical, surgical, or vision services rendered, not to exceed the reasonable and customary charges. I understand that I am financially responsible for charges not covered, authorized or paid by my insurance. I understand that balances not paid by my insurance carrier after **90 days** may become my responsibility. Patient balances over 90 days will be assessed a monthly finance fee of **4%** if arrangements have not been made with the billing department. Accounts turned over to collections will be assessed a processing fee of **\$25.00**.

I understand that I must give 24 hour notice when cancelling or rescheduling an appointment. Failure to do so will result in a **\$25.00** fee.

All returned checks will be assessed a \$25.00 fee.

**I have received a copy of the Arezo Amirikia, M.D., P.C. Notice of Privacy Practices for Protected Health Information.**

Print Name \_\_\_\_\_

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_