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Telephone: 586-228-7563 Fax: 586-228-8377

Patient's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home: _____ Work: _____ Other: _____

Birthdate: _____ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Social Security Number: _____ Sex: ☐ Male ☐ Female

Referring Physician: _____ Telephone number: _____

Primary Physician: _____ Telephone number: _____

Spouse/Guardian: _____ Telephone number: _____

Emergency Contact: _____ Telephone number: _____

Nearest Relative Not Living With You: _____ Telephone number: _____

Driver's License #: _____ Cell Phone number: _____

Patient's Employment: Employment Status: ☐ Employed ☐ Retired ☐ Self-Employed ☐ Other: _____

Employer: _____ Telephone number: _____

Address: _____ City/State/Zip: _____

Spouse Employment: Employment Status: ☐ Employed ☐ Retired ☐ Self-Employed ☐ Other: _____

Employer: _____ Telephone number: _____

Social Security Number: _____ Birthdate: _____

Insurance Information: The office will make a copy of your cards.

Primary Insurance: _____

Insured's Name: _____ Birthdate: _____

Secondary Insurance: _____

Insured's Name: _____ Birthdate: _____

Is your visit auto related: ☐ Yes ☐ No Work related: ☐ Yes ☐ No

If yes, contact person: _____ Telephone number: _____

Please describe how the injury/illness occurred: _____

_____

_____

Medications: Please list all medications (including over-the-counter and vitamins) that you are currently taking. Please include dosage of each.

Medication Name	Dose	Frequency

Allergies: Please list all allergies:

Illnesses or Operations: Please list all major illnesses and operations.

Family history: Is there any aneurysm of the brain, cancer, or other demyelinating disease?

Patient's previous medical history: Please check yes or no if you have experienced any of the following:

Allergic Reaction to Medication	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No
Blood Transfusions	☐ Yes	☐ No
Colitis	☐ Yes	☐ No
Convulsions	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Gallbladder Disease	☐ Yes	☐ No
Gonorrhea	☐ Yes	☐ No
Gout	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No
Heart Failure	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Hepatitis A, B, or C	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Intestinal Disease	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Mononucleosis	☐ Yes	☐ No
Paralysis	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Steroid Medications	☐ Yes	☐ No
Stomach Disease	☐ Yes	☐ No
Syphilis	☐ Yes	☐ No
Ulcer Disease	☐ Yes	☐ No

If you have any other experiences or answered yes to any questions above, please describe:

_____

_____

Releases:

Workmen's Compensation:

My signature below acknowledges that my condition is not the result of a work-related injury.

Signature: _____ Date: _____

Auto Accident:

My signature below acknowledges that my condition is not the result of an automobile accident.

Signature: _____ Date: _____

Office and Financial Policy:

Our practice is committed to providing you with the best possible treatment and we charge what is customary in our area. Full payment is expected at the time of service, unless other arrangements are made with our billing department prior to your visit. If you have insurance coverage, please understand that this is a contract between you and your insurance company. As a courtesy to you, we will help you receive your benefits by submitting medical claims for reimbursement provided that we receive all the necessary information.

We participate in Blue Cross, Medicare, and selected PPO and HMO companies which may require a deductible and co-payment to be met. It is your responsibility to make sure we participate with your insurance plan. Also, that you have the required referral and authorization information with you at the time of service. If you are required to have any lab work, radiology, or other testing, it is your responsibility to inform our office if the testing needs to be done at a specific location or if pre-authorization is required.

Unless we receive a 24-hour notice of cancellation of your appointment, we reserve the right to charge for the missed appointment at the rate of a normal office visit. To help us better serve you, please keep your scheduled appointments.

The adult accompanying a minor or the patients/guardians are responsible for full payment. For an unaccompanied minor, non-emergent care will be denied unless the minor patient arrives with a signed permission note with the date of service and a telephone number where the parent or guardian can be reached.

Authorization to Release Medical Information:

I hereby authorize Manouchehr Nikpour, P.C. to receive and/or release any medical or other information that may be necessary for the medical care or processing of insurance applications. This includes the sharing of information with all parties involved in my care, such as nursing care facilities, physicians, and hospitals. All means may be utilized, including electronic transmissions.

Assignment of Insurance Benefits:

I hereby authorize direct payment of medical benefits to Manouchehr Nikpour, P.C. for services rendered by one of their physicians or for services rendered under their direct supervision. I authorize any holder of medical or other information about me to release to the health insurance company any information needed to determine benefits for related services. I understand that I am financially responsible for any balance not covered by my insurance.

Authorization for Medicare or Medicaid:

I certify that the information given to me in applying for payment is correct. I authorize the release of all records on request. I request that payment of authorized benefits be made on my behalf.

Releases:

My signature below acknowledges my understanding that I have never been involved with a malpractice case against any physician and there are no pending litigations involved with the condition that I am undergoing treatment for. I also ^acknowledge that I have received the office policies/information packet.

Collection Accounts:

I understand that if my account goes into collection, I will be responsible for the balance owed, plus any fees associated with the collection.

Patient's Name (print): _____ Signature: _____

Guardian (print): _____ Signature: _____

Date: _____

[NAME OF PRACTICE]

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned Patient or legally authorized representative ("Agent") of the Patient acknowledges that he or she personally received a copy of the [NAME OF PRACTICE]'s Notice of Privacy Policies on the date indicated below.

Signature: _____ Date: _____

Patient: _____

Information about Agent (attach appropriate documentation):

Agent: _____

Title: _____