

PATIENT INFORMATION SHEET

DATE: _____

Patient Name: _____ DOB: _____

Address: _____ City _____ State _____ Zip Code _____

Telephone: _____ Cell _____ SS#: _____

Patient's Employer: _____ Work Phone#: _____

Spouse: _____ DOB: _____

Telephone #: _____ SS#: _____ Email: _____

EMERGENCY CONTACT

Name: _____ Telephone: _____

Primary Care Physician: _____ Telephone: _____

Name of Referring Physician: _____ Telephone: _____

If patient is a minor, Please Complete:

Father's Name: _____ DOB: _____ SS#: _____

Father's Employer: _____ Work #: _____

Mother's Name: _____ DOB: _____ SS#: _____

Mother's Employer: _____ Work #: _____

INSURANCE: (Please circle) **MEDICAL** **AUTOMOBILE** **WORKERS COMP** **SELF PAY**

Co. Name: _____ Policy #: _____

Subscriber: _____ DOB: _____

Address: _____ Phone #: _____

Secondary Ins.: _____ Policy#: _____

Subscriber: _____ DOB: _____

Address: _____ Phone#: _____

Adjustor/ Contact Name _____

Attorney's Name: _____ Telephone #: _____

If there is a suit files in this case, I agree to have Dr. Samra paid from the proceeds of that settlement should any balance on my account exist.

I authorize the release of any medical information necessary to process my claim. I hereby authorize payment directly to the Samra Group. I understand I am financially responsible to the doctor for charges not covered by this assignment. I understand the balances for which I am responsible are subject to interest charges if payments are delinquent (1.5% per month).

Cost of Collection: If this account becomes delinquent, I may be responsible for additional billing costs; and if this account is assigned to a collection agency or attorney for collection, I agree to the addition of a collection fee of \$50.00 or 35% of the balance owed, whichever is greater. I acknowledge a fee of \$40 or the actual bank charge, whichever is greater, for any returned check.

Authorization for Disclosure of Information:

I authorize The Samra Group to disclose complete information concerning medical findings and treatment of the undersigned, from the initial office visit until the date of the conclusion of such treatment, to those individuals who, in Dr. Samra's sole determination, are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review.

A photocopy of this form shall be considered as valid as the original.

Patient/ Subscriber Signature _____ Date _____