PATIENT REGISTRATION FORM

Patient Name: ______________________ ______________ Date of Birth: _____________

Marital Status: _____ Social Security Number: ______- ______ - ______ SEX: M___ or F___

Address:_____________________________________ _____ City: __________________________

State: ________________ County: _____________________________ Zip Code: ___________

Phone: Home: ____________________ Cell: __________________ Preferred: Home or Cell

E-mail: ___________________________

Employer: ______________________________________ Employer Phone_________________

Employer Address____

Insurance Company 1st: ___________________________ 2nd: ___________________________

Insurance Subscriber's Name _____________________________ Relationship: ____________

Insurance Subscriber's Date of Birth: ________________ SSN#: ___________________________

Emergency Contact: _____________________________ Relationship: ___________________

Address: ____ Phone: ___________________

I consent to treatment necessary for the care on the above named patient.
I authorize the release of all medical records to the referring and family physicians and to my insurance company.
I allow fax transmittal of my records.
I acknowledge full financial responsibility for services rendered by Dr. Amjad Rass. INC.
I understand that payment of charges incurred is due at the time of services unless other financial arrangements have been made prior to treatment.
I further authorize and request that insurance payments be made directly to Amjad. Rass M.D.INC.
I have read and fully understand the above consent.

Signature: ____ Date: ______________________

Pharmacy____

I understand that I am being seen as a "**walk-in**" patient only and that I am **not an established patient** *of this practice. I understand that my* ***"INSURANCE"*** *may not cover my visit* and or be **out of network**. I also **Understand** my Insurance will be billed as a **NORMAL Doctor** visit and **NOT** as an **Urgent Care**.

______________________________ ______________________________

PATIENT/GUARDIAN SIGNATURE DATE

____I

understand that I am being seen as a "**walk-in**" patient only and that I am **not an established patient** of this practice.

I, ___________________________________understand that the office of Dr. Rass was unable to verify my insurance coverage. I accept responsibility for payment if my insurance doesn't cover the visit.

Signature__________________________Date____________