

**MOHAMMAD K. ARAB, M.D., F.A.C.S.**

ENT CLINIC

516 W. Aten Road, Suite 4

OFFICE: (760) 355-8500 FAX: 355-8558

**PATIENT IDENTIFICATION**

SEX:  M  F

LAST NAME \_\_\_\_\_ NAME \_\_\_\_\_ INITIALS \_\_\_\_\_

ADDRESS \_\_\_\_\_ MAILING ADDRESS \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_  
 SINGLE  MARRIED

PHONE NUMBER \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_ CELL PHONE NUMBER \_\_\_\_\_ MARITAL STATUS:  DIVORCED  WIDOW

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_ REFERRED BY \_\_\_\_\_ ADDRESS \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SPOUSE'S SSN \_\_\_\_\_ SPOUSE'S EMPLOYER \_\_\_\_\_

PERSON TO NOTIFY IN CASE OF EMERGENCY (NAME & RELATION) \_\_\_\_\_ ADDRESS \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

**INSURANCE INFORMATION**

**PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST**

NAME OF PRIMARY INSURANCE \_\_\_\_\_ INSURANCE ADDRESS \_\_\_\_\_ INSURANCE PHONE NUMBER \_\_\_\_\_

INSURED'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SSN \_\_\_\_\_ POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_

NAME OF SECONDARY INSURANCE \_\_\_\_\_ INSURANCE ADDRESS \_\_\_\_\_ INSURANCE PHONE NUMBER \_\_\_\_\_

INSURED'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SSN \_\_\_\_\_ POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_

**FINANCIAL RESPONSIBILITY**

LAST NAME \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ RELATIONSHIP TO PT \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

EMPLOYER NAME \_\_\_\_\_ EMPLOYER ADDRESS \_\_\_\_\_ BUSINESS/CELL PHONE \_\_\_\_\_

- I consent to treatment necessary for the care of the above named patient.
- I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.
- I acknowledge full financial responsibility for services rendered by the physician if my insurance denies or reduces payment.
- I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
- I further authorize and request that insurance payments be made directly to: Mohammad K. Arab, M.D., F.A.C.S.
- I am also aware that there is a \$30.00 fee for returned checks. Should my account be turned over to a collection agency, I am responsible for 30% added to the collection fees plus any legal fees.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_