PATIENT INFORMATION

NAME: ____

ADDRESS: ____

____

HOME PHONE: __________________ **WORK/CELL**: __________________

DATE OF BIRTH __________________ **SOCIAL SECURITY #** __________________

SINGLE **SEPARATED** **MARRIED** **DIVORCED** **WIDOWED**

EMPLOYED BY:__________________ **OCCUPATION** __________________

BUSINESS PHONE: ____

EMERGENCY CONTACT: ____

PHONE: __________________ **RELATIONSHIP**: __________________

INSURANCE: __________________ **ID#** __________________

NAME OF SUBSCRIBER: __________________ **DATE OF BIRTH** __________________
(Spouse/parent) (Spouse/parent)

MEDICARE#__________________ **MEDEX #** __________________

MEDICAID/MASSHEALTH ____

REFERRED BY ______________________________

**** DO YOU HAVE ANY ALLERGIES** ______________________________

I hereby authorize my insurance benefits to be paid directly to the above signed physician, realizing I am responsible for non-covered services and I hereby authorize the release of pertinent medical information to insurance companies.

X ______________________________ **DATE** __________________
(Signature)

I acknowledge that I have been advised of the privacy practices (HIPAA) for the office of Wissam J. Khoory, M.D.

X______________________________ ______ **DATE** __________________
(Signature)