

FARDAD MOBIN , M.D.

Patient Registration Information

Date: _____ **Social Security Number:** _____

Patient Name: _____

Home Phone: _____ **Work** _____

Address: _____ **City:** _____ **State:** _____ **Zip** _____

Date of Birth: _____ **Age** _____ **Gender:** _____ **Marital Status:** _____

- 1. If it becomes necessary to contact you by phone, do we have your permission to leave message regarding lab results and/or appointment on your answering device, or another person who answers the phone? (please circle one) YES or NO
- 2. What is the best time of the day to reach you? _____
- 3. Where do you prefer to receive calls? (circle one) HOME WORK CELL
- 4. Name of emergency contact person (not living with you)? _____
Phone: _____ Relationship: _____

Insured/Responsible Party Information: Self? _____ **Relationship, if not self:** _____

Name on Insurance Card, if other than "Self"? _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____

Employer Name: _____

Primary Insurance: _____

Secondary Insurance: _____

Assignment of Benefits: I understand that I am responsible for the payment to Fardad Mobin, M.D. for medical services performed on me; and I hereby assign whatever benefits to which I may be entitled by my health insurance to Dr. Mobin for those medical services extended on my behalf. (PATIENT INITIALS) _____

Release of medical information: I hereby authorize the release of any medical information about me that may be necessary to adjudicate claims for reimbursement to Fardad Mobin, M.D., for any medical services rendered by him on my behalf. (Patient Initials) _____

Patient Signature: _____ **Date:** _____