# REGISTRATION INFORMATION

Date:______________________ (Please Print) Home Phone:______________________

Patient:______________________________________________________________
Last Name First Name Initial

Street Address:______________________________________________________

City:__________________State________________Zip:________Cell:______________

Birthdate:______________ ___Single ___Married ___Separated ___Divorced ___Widowed

E-Mail Address______________________________________________________

Patient Employed By:_________________________________________________

Business Address:___________________________________________________

Occupation:_________________________________________________________

Purpose of Visit:____________________________________________________

Spouse (or responsible party) employed by:_____________________________

Business Address:___________________________________________________

Occupation:___________________________Business Phone:_______________

Spouse (or responsible party) Date of Birth:____________________

Who is responsible for this account?__________________Relationship to patient______________

Do you have medical insurance? _____NO _____YES, if yes,

Name of Primary Insurer:______________________________________________

Insurance Identification Number:_______________________________________

Name of Secondary Insurer (if any):____________________________________

Secondary Insurance identification number:_____________________________

In case of emergency, who should be notified?:____________________Phone:______________

Your Drugstore Name:____________________________________Phone:______________

How did you learn of our practice?______________________________________

## ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I ______________________________hereby authorize______________________________
(Name of Insured) (Name of Insurance Company)

to pay and hereby assign directly to Fayez Guirguis, MD all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Fayez Guirguis, MD will be credited to my account, in accordance with the above said assignment.

______________________________ ______________________________
(Authorized Signature of Subscriber) (Date)

We would appreciate if you answer the following questions. If you do not wish to answer , please circle **patient declined** and return.
Thank you.

Name:________________________________________

**Race**

White

Black/African American

American Indian/Alaska Native

Asian

Other

Patient Declined/Unknown

**Ethnicity**

Spanish/Hispanic Origin

Not ofSpanish/Hispanic Origin

Patient Declined/Unknown

**Language**

________________________________

PLEASE CHOOSE YOUR PRIVACY OPTIONS

## HIPPA PRIVACY INFORMATION

**How may we leave messages regarding appointments:**

| | | |
|---|---|---|
| Home Phone (Include Auto Call) | Yes | No |
| Mobile Phone (Include Auto Call) | Yes | No |
| Mobile Text (Include Auto Call) | Yes | No |
| Work Phone | Yes | No |
| With Another Person | Yes | No |
| Send via Mail | Yes | No |
| Send via E-Mail | Yes | No |

**How may the doctor / midwife / nurse practioner leave medical information:**

| | | |
|---|---|---|
| Home Phone (Include Auto Call) | Yes | No |
| Mobile Phone (Include Auto Call) | Yes | No |
| Mobile Text (Include Auto Call) | Yes | No |
| Work Phone | Yes | No |
| With Another Person | Yes | No |
| Send via Mail | Yes | No |
| Send via E-Mail | Yes | No |

**Person (s) Authorized to Communicate With:** ______________________________

______________________________