WESTSIDE MEDICAL CLINIC

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____/_____/_____
Last First Middle Initial MM / DD / YY

SSN: _____ / _____ / _____ SEX: ☐ M ☐ F MARITAL STATUS: ☐SINGLE ☐MARRIED ☐DIVORCED ☐PARTNER ☐WIDOWED ☐OTHER

ADDRESS: _____ APT. # _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____) _____- _____ MOBILE PHONE: (_____) _____ - _____

WORK PHONE: (_____) _____- _____ Ext: _____ **EMAIL ADDRESS**: _____

EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP: _____ PHONE: _____

Race: ☐American Indian/Alaska Native ☐Asian ☐Native Hawaiian ☐Black/African American ☐White ☐Hispanic ☐ Other

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Refused to Report

Primary Language: ☐English ☐Spanish ☐Indian ☐Russian ☐Other _____

Advance Directive: ☐**YES** ☐**NO** (Legal documents that allow you to convey your decisions about end-of-life care ahead of time, also known as living will)

Pharmacy Name: _____ **Pharmacy phone number** _____-_____-_____ **or Intersection** ↓

Mail Order Pharmacy Name: _____ _____

INSURANCE SUBSCRIBER ☐ **SELF** ☐ **SPOUSE** ☐ **PARENT** ☐ **SELF PAY**
☐**WORKERS COMPENSATION** ☐ **OTHER** _____

(IF YOU ARE THE SUBSCRIBER SKIP THIS SECTION)

NAME: _____ DATE OF BIRTH: _____/_____/_____
Last First Middle Initial MM / DD / YY

SSN: _____ / _____ / _____ SEX: M: ☐ F: ☐ EMPLOYER: _____

PRIMARY INSURANCE

INSURANCE CO. NAME _____ PLAN TYPE: HMO / PPO / POS ☐ Other: _____

MEMBER ID # _____ GROUP #_____

SECONDARY INSURANCE: ☐**YES** ☐**NO** **If YES Name:** _____

I authorize Syed V. Ahmed, M.D., P.A. and his staff at Westside Medical Clinic to release any information obtained in the course of my treatment to my insurance company, employer, or third party payer, governmental agency as required for filing claims, quality assurance, health plan administration, public health and complains follow-up. I authorize direct payment to be made to Syed V. Ahmed, M.D., P.A. for any and all medical services provided. **I understand that if any services or charges are not covered I will be responsible for all charges incurred. I have received and understand the Notice of Privacy Practices.**

PATIENT/GUARANTOR SIGNATURE: _____ DATE: _____

Rev. 02/27/2015