NEW PATIENT INFORMATION (PLEASE PRINT E-MAIL ADDRESS_____

NAME (LAST, FIRST, MI)_____ AGE_____

ADDRESS_____

CITY_____STATE_____ZIP_____

HOME PHONE_____ WORK/CELL _____ MARTIAL STATUS: M D W S

SS# _____ DOB _____/_____/_____ M / F HEIGHT _____ WEIGHT _____

EMPLOYER_____ OCCUPATION _____

ADDRESS _____

SPOUSE'S NAME _____ EMERGENCY CONTACT NUMBER _____

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NAME OF RESPONSIBLE PARTY_____ DOB _____/_____/_____

RELATIONSHIP _____ SS#_____ HOME PHONE _____

ADDRESS_____ CITY _____ ZIP _____

EMPLOYER _____ WORK PHONE _____

EMP. ADDRESS _____ OCCUPATION _____

CITY _____ STATE _____ ZIP _____

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PRIMARY INSURANCE CO._____SUBSCRIBER ID #_____GROUP #_____

POLICY HOLDER _____SS#_____

SECONDARY INSURANCE CO. _____ SUBSCRBER ID #_____GROUP #_____

POLICY HOLDER _____ SS#_____

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REASON FOR VISIT _____ DATE OF ONSET_____

NAME OF PRIMARY CARE _____REFERRING PHYSICIAN_____

PLEASE READ: ALL CHARGES ARE DUE AT THE TIME OF SERVICE. IF SURGERY IS INDICATED THE PATIENT IS RESPONSIBLE FOR FURNISHING INSURANCE INFORMATION TO THE OFFICE. ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. THE PATIENT OR RESPONSIBLE PARTY IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE.
I, THE UNDERSIGNED, ASSIGN DIRECTLY TO LEILIE JAVAN, MD, FACS A MEDICAL CORPORATION, ALL MEDICAL AND/OR SURGICAL BENEFITS, IF ANY, OTHERWIESE PAYABLE TO ME FOR SERVICES RENDERED. I EXPRESSLY AUTHORIZE THE SAID DOCTOR TO FURNISH THE INSURANCE COMPANY OR its REPRESENTATIVES ANY INFORMATION INCLUDING THE DIAGNOSIS AND RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY DEPENDENTS DURING THE PERIOD OF SUCH MEDICAL OR SURGICAL CARE. I ALSO UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE DOCTOR FOR ALL CHARGES NOT COVERED BY THIS AGREEMENT.

SIGNED (PATIENT)_____ SIGNED (POLICY HOLDER)_____

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PERMISSION FOR PHOTOGRAPHS

I HEREBY AUTHORIZE LEILIE JAVAN, MD, FACS A MEDICAL CORPORATION TO PHOTOGRAPHHY OR PERMIT OTHR PERSONS TO PHOTOGRAPH ME WITH THE UNDERSTANDING THAT SUCH PHOTOGRAPHS ARE FOR CONFIDENTIAL CLINICAL PURPOSES AND THAT ALL PHOTOGRAPHS ARE THE PROPERTY OF THE DOCTOR.

DATE_____ PATIENT'S/GUARDIAN'S SIGNATURE_____