MEHDI BAJOGHLI, M.D., F.A.C.A.I.
ARVEEN THETHI, M.D.

PATIENT INFORMATION DATE:_____

Patient Name:_____
(Last) (First) (MI)

Address:_____
(Street Address) (Town/City) (State) (Zip)

Telephone No: _____ Age:_____ Sex:_____ Birthdate:_____

Marital Status: _____ Single _____ Married _____Other SS#:_____

Is patient ____employed ____full-time student ____part-time student Cell Phone No._____
Email Address_____

Patient's Employment Information:
Name of Employer:_____ Phone:_____
Address:_____

Insured's Employment Information:
Name of Employer:_____Phone:_____
Address:_____

Name of Parents or guardian (if patient is child):
Father:_____ SS#:_____
Mother:_____ SS#:_____

Name of Spouse:_____ SS#:_____

Name of nearest relative:_____ Phone:_____
Address:_____

Name of Family/Referring Physician_____Phone:_____
Address:_____

Whom should we thank for referring you to us?:_____

INSURANCE INFORMATION
Name of Insurance _____ Phone:_____
Address:_____
ID:_____ Group Name or No:_____
Name of Policyholder:_____ Birthdate:_____
Address:_____
Employer Insurance Plan? _____ Yes _____ No
Relationship of Patient to Policyholder: ____Self ____Husband ____Wife ____Child ____Parent

ASSIGNMENT & RELEASE

For Patients under eighteen (18) years of age:
I hereby authorize Dr. Bajoghli and his staff to perform skin test and to administer hyposensitization (allergy injections) to _____
(Name of Child)
and render any emergency treatments deemed necessary, if he/she should be brought to this office by anyone other than myself.

_____ _____
Signature of Parent or Guardian Date

(OVER)

I hereby authorize this office to apply for benefits on my behalf for covered services rendered.

I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information for this or any related claim to my insurance carrier. A copy of this authorization may be used in place of the original.

I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to this office for services rendered. I also shall notify this office for any change of my health insurance.

I understand and agree that I am financially responsible for charges, not my insurance company. I understand that I am responsible for the payments of all charges for services rendered, regardless of insurance, and that any amount remaining unpaid more than 30 days after the services were rendered will accrue interest at a rate of 12% per annum. Should the account be turned over to an attorney, I agree to pay 33.3% attorney's fees and all court costs.

Allergy work-up is usually covered under major medical insurances. We will be glad to submit a computerized claim form to your primary insurance at no charge to you. To avoid inefficiency and confusion, please understand that you, and not your insurance company, are responsible for medical bills. Therefore, we expect you to begin payment on your account when you receive the billing charges. If they send us a check and you have already paid the bill, we will credit your account or forward a reimbursement check to you.

All HMO patients are responsible for their referrals from their primary care physicians.

X_____ _____

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN DATE