Name: Last, First & Middle Initial: _____

Address: _____

Street City State Zip

Age: _____ D.O.B.: _____ Marital Status (Circle One): S M W D

Home Ph:_____ Cell Ph: _____ S.S. #: _____

Email Address:_____

Emergency Contact: Name: _____ Phone: _____

Pharmacy:_____ **Phone:**_____

Address: _____

Employer: _____ Occupation: _____Business Ph: _____

Do You Have Insurance Coverage?: (Circle) YES / NO

Name of Insurance: _____ PPO/EPO/POS/HMO: _____

Primary Insurers Name: _____ D.O.B.: _____

Referral Source: _____Ph.#: _____Fax#: _____

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS: I hereby authorize DEBORA S. SEDAGHAT, D.O., to disclose any medical records when requested by the named insurance carrier or its representatives, including all information with respect to any illness (es), or injury (ies), medical history, or treatments with copies of all necessary medical records. Notice: A $25.00 fee will be required upon any medical record request. A photo static copy of this authorization shall be considered as effective and valid as the original.

I hereby also authorize payments directly to DEBORA S. SEDAGHAT, D.O., of the surgical and/or medical benefits, if any, otherwise payable to me for the professional services rendered to me. I understand that I am financially responsible for the charges not covered by this authorization. I further agree in the event of nonpayment, to bear the cost of reasonable legal fees should this be required. I also understand that future appointments will not be made unless the payments are paid in full.

CANCELLATION: If you cannot come to your scheduled appointment, please call the office at least 24 hours prior to your appointment. This allows us to fill the time with another patient. A $25.00 charge may be applied if at least 24 hours notice is not given. Fees have to be paid before another appointment can be made. The office also reserves the right of not making any future appointments if a scheduled appointment is not cancelled and the patient does not show up for the scheduled appointment.

LATE ARRIVALS: Please be on time for your appointment. If you are more than 15 minutes late, we may have to reschedule your appointment.

UNATTENDED CHILDREN: We ask that children not be in the examining or treatment room except in the cases where the doctor deems it necessary. This is for the safety of the child. If the children are disruptive in the waiting area, we will ask that the parent, guardian or family member to reschedule their appointment to another time when proper supervision can be provided.

Date: _____

Patient Name: _____

Patient Signature:_____

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