ARTHRITIS AND RHEUMATOLOGY CLINIC
Dr Mohammad Shakir

PRINT NAME _____ **Date of Birth** _____

MAILING ADDRESS _____

CITY & STATE _____ **Zip Code** _____

PERMANENT ADDRESS _____

HOME PHONE # / CELL PHONE # _____

Martial Status _____ **Spouse Name** _____

EMERGENCY CONTACT NAME & PHONE & RELATIONSHIP

PRIMARY INSURANCE _____

Policy Holder Name _____ **DOB** _____

Social Security # _____

SECONDARY INSURANCE _____

Policy Holder Name _____ **DOB** _____

Social Security # _____

Retired Yes / No _____ **Employer** _____

Primary Care Physican Name & Phone number _____

Pharmacy Name / City / Phone _____

RACE (CHECK)

___ American Indian or Alaska Native **____ Asian** **____ Native Hawaiian or Other Pacific Islander**

___ Black **____ Hispanic** **____ White**

___ Other Race **____ Unreported / Refused to report**

ETHNICITY (CHECK)

___ Hispanic or Latino **____ Not Hispanic or Latino** **_____ Refused to report**

Assignment and Release

I hereby authorize and request that payments under my insurance plans be made directly to Arthritis & Rheumatology Clinic PC for any services furnished to me. I also authorize the release of any information required to process insurance claims. I agree to pay my co-pay at the time of service and I understand that I am financially responsible for all charges not covered by my insurance. I agree that if I do not possess current insurance coverage, I will pay in full for services rendered at the time of service. I understand that I am responsible for all costs of collection and reasonable attorney's fees should collection become necessary.

I understand that I am responsible to give 24 Hrs notice for cancellation or rescheduling my appointment. I hereby authorize the Arthritis and Rheumatology clinic **to charge twenty five dollars** for cancellation and missing appointment without prior notification.

I hereby consent to the administration and performance of all diagnostic procedures and/or treatments which in the judgement of my physician may be considered necessary and advisable. I am entitled to a full explanation prior to any testing, procedure, or referral and that I have the option to decline such treatment or seek further information.

Signature: _____ **Date:** _____

(If patient is a minor – signature of parent/guardian)