WESTCHASE HEALTH CLINIC

PATIENT INFORMATION Page 1

NAME: _____ DATE OF BIRTH: _____
Last First Middle Initial

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

ADDRESS: _____APT. # _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____) _____- _____ WORK PHONE: (_____) _____ - _____

MOBILE PHONE: (_____) _____- _____ EMAIL ADDRESS: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: _____

PATIENT'S EMPLOYER: _____ EMPLOYER'S PHONE: _____

EMPLOYER'S ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

REFERRED BY: _____

PHARMACY PHONE: _____ PHARM. FAX: _____ PHARM. ADDRESS: _____

INSURANCE SUBSCRIBER ☐ SELF PAY (IF YOU ARE THE INSURANCE SUBSCRIBER FILL IN YOUR SPOUSE'S INFORMATION HERE)

PATIENT RELATIONSHIP: ☐ SELF ☐ SPOUSE ☐ CHILD

NAME: _____ DATE OF BIRTH: _____
Last First Middle Initial

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

ADDRESS: _____ APT.# _____

CITY: _____ STATE:_____ ZIP:_____

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

EMPLOYER: _____ WORK NUMBER: (_____) _____ - _____

PRIMARY INSURANCE

INSURANCE CO. NAME _____ PLAN TYPE _____ GROUP #_____

INSURANCE CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

SUBSCRIBER NAME _____ MEMBER ID # _____ DOB _____

EMPLOYER _____ ELIGIBILITY PHONE #_____ EFF.DATE _____

SECONDARY INSURANCE

INSURANCE CO. NAME _____ PLAN TYPE _____ GROUP #_____

INSURANCE CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

SUBSCRIBER NAME _____ MEMBER ID # _____ DOB _____

EMPLOYER _____ELIGIBILITY PHONE #_____ EFF. DATE _____

ACKNOWLEGEMENT OF FINANCIAL RESPONSIBILITY

All Co pays, Coinsurance and Deductibles are due at the time services are rendered. We bill your insurance company for professional Services on your behalf as a courtesy and convenience for you; however this office does not accept responsibility for collecting your insurance proceeds or for negotiating settlement of a disputed claim. If for whatever reason your insurance company does not pay your claim in full, you are responsible for payment of the entire balance including any finance charge or collection fees that may be included.

Signature: _____ Date: _____

ASSIGNMENTS OF BENEFITS

I assign all direct payments from Medicare, Private Insurance and other Health Plans to be made to Tanveer Syed, M.D., P.A. for any and all medical services provided.

I authorize Tanveer F. Syed, M.D., P.A. and her staff at Westchase Health 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 complaints follow-up. **I have received and understand the Notice of Privacy Practices.**

PATIENT/GUARANTOR SIGNATURE:_____ DATE:_____