SAED J. SAHOURI, M.D., PLLC

PATIENT REGISTRATION

Name: _____ SS#: _____
First Middle Last Birthdate: _____
Address: _____ Phone: ( ) _____
City: _____ State: _____ Zip Code: _____ Mobile: ( ) _____
Sex: ____M ____F Marital Status: ____S ____M ____D ____W Email Address: _____

Employer: _____ Occupation: _____ Years There: _____
Employer's Address: _____ Work Phone: ( ) _____
City: _____ State: _____ Zip Code: _____

Spouse/Legal Guardian:

Name: _____ Relationship: _____
First Middle Last SS#: _____ Birthdate: _____
Address: _____ Phone: ( ) _____
City: _____ State: _____ Zip Code: _____ Work Phone: ( ) _____

Nearest Relative/Emergency Contact (Not Residing at the Same Address):

Name: _____ Relationship: _____
First Middle Last Phone: ( ) _____
Address: _____ Work Phone: ( ) _____
City: _____ State: _____ Zip Code: _____

Other Information: _____

I hereby voluntarily request, consent to, and authorize Saed J. Sahouri, M.D., PLLC to provide medical and minor surgical treatments. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of examination and treatment which I have hereby authorized.

I authorize Saed J. Sahouri, M.D., PLLC to release any medical information necessary to process insurance claims. I also authorize payment of medical and surgical benefits to Saed J. Sahouri, M.D., PLLC.

I assume full financial responsibility for payment of all services provided to me, including any portion of my bill that is not paid by my insurance(s), workers' disability compensation, or social agencies.

I acknowledge that I have received or have been offered a copy of this office's ***Notice of Privacy Practices Form****.*

I understand the content and significance of this form, and my questions have been answered.

_____ _____
Patient/Legal Guardian Signature (Relationship) Date

_____ _____
Witness Signature Date