Yafa Minazad, D.O., Inc

Neurology, Critical Care and Neurophysiology

PATIENT REGISTRATION RECORD

PATIENT INFORMATION

Last Name	First	M.I.	Home # ( )	Date
Street Address	Apt #		Work # ( ) ext.	Cell # ( )
City	State	Zip Code	Sex ☐ Male ☐ Female	Date of Birth / /

Social Security # - -	Driver's License #	Referring Physician	Phone # ( )

FINANCIALLY RESPONSIBLE PARTY

Last Name	First	M.I.	Relationship ☐ Mother ☐ Father ☐ Spouse ☐ Legal Guardian
Street Address	Apt #	Home # ( )	Cell # ( )
City	State	Zip Code	Work # ( )	Ext. #

EMPLOYER INFORMATION

Employer Name	Occupation
Employer Address	Suite #	Home # ( )	Cell # ( )
City	State	Zip Code	Work #	Ext. #

INSURANCE INFORMATION

Medicare #	Medi-Cal #	Issue Date
Primary Insurance	Subscriber #	Group #
Insurance Mailing Address	Relation to Patient	Subscriber Name & Date of Birth
Secondary Insurance	Subscriber #	Group #
Insurance Mailing Address	Relation to Patient	Subscriber Name & Date of Birth
Worker's Compensation Insurance	Claim #	Adjuster Name	Phone # ( )
Worker's Compensation Mailing Address	Relation to Patient	Subscriber Name & Date of Birth

EMERGENCY CONTACT INFORMATION

Last Name	First	M.I.	Relationship ☐ Mother ☐ Father ☐ Spouse ☐ Legal Guardian
Street Address	Apt #	Home # ( )	Cell # ( )
City	State	Zip Code	Work #	Ext. #

ASSIGNMENT OF BENEFITS:

*I hereby authorize **Yafa Minazad, D.O., Inc.** to furnish information to insurance carriers concerning this illness. I hereby irrevocably assign to **Yafa Minazad, D.O., Inc.** all payments for medical services rendered and all major medical benefits.*

CONSENT FOR TREATMENT:

*I hereby authorize my consent to be treated now and in the future at **Yafa Minazad, D.O., Inc.'s** office.*

Signature of Patient/Insured: ______________________ ***Date:*** ______________