PATIENT INFORMATION:

PATIENT'S NAME_____ SOCIAL SECURTIY NUMBER_____

ADDRESS_____ DATE OF BIRTH_____

CITY_____ STATE_____ ZIP_____ HOME PHONE_____

PLEASE PROVIDE YOUR E-MAIL ADDRESS IF YOU WOULD LIKE TO VIEW YOUR MEDICAL RECORDS ONLINE.

E-MAIL ADDRESS _____ ALTERNATIVE PHONE NUMBER_____

OK TO E-MAIL YOU WITH COSMETIC SPECIALS? ☐ YES ☐ NO

IF THE PATIENT IS A MINOR, THE INDIVIDUAL COMPLETING THE INTIAL PAPERWORK IS RESPONSIBLE FOR ALL FEES REGARDLESS OF GUARDIANSHIP OR CUSTODY ARRANGEMENTS. IF THIS ADDRESS DIFFERS FROM THE PATIENT PLEASE PROVIDE THE CORRECT BILLING ADDRESS BELOW:

_____

RACE:

_____ WHITE _____AMERICAN INDIAN/ALASKA NATIVE _____ASIAN _____BLACK OR AFRICAN AMERICAN

_____NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER _____REFUSE TO REPORT/UNREPORTED

EMPLOYER INFORMATION

EMPLOYER'S NAME_____ OCCUPATION_____

MAY WE CONTACT YOU AT WORK? ____YES ____NO WORK NUMBER_____

COMPLETE ONLY IF PATIENT IS A MINOR

MOTHER'S NAME_____ OCCUPATION_____

MAY WE CONTACT YOU AT WORK? ____YES ____NO WORK NUMBER_____

FATHER'S NAME_____ OCCUPATION_____

MAY WE CONTACT YOU AT WORK? ____YES ___NO WORK NUMBER_____

WHO DOES CHILD RESIDE WITH?_____MOTHER _____FATHER _____BOTH

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT _____

TELEPHONE_____ RELATIONSHIP_____

HOW DID YOU HEAR ABOUT DR. YAISH? ____PHYSICIAN ____FAMILY/FRIEND ____INTERNET ____OTHER

WHO IS YOUR FAMILY PHYSICIAN_____

IF YOU WERE REFERRED HERE PLEASE LIST NAME: _____

PLEASE LIST ANY OTHER FAMILY MEMBERS SEEN BY DR. YAISH_____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE

I AUTHORIZE DR. A. DANNY YAISH D.O. TO RELEASE/ RECEIVE ANY MEDICAL OR INCIDENTAL INFORMATION THAT MAY BE NECESSARY FOR EITHER MEDICAL CARE OR IN PROCESSING APPLICATIONS FOR FINANCIAL BENEFITS. I AUTHORIZE DIRECT PAYMENT OF BENEFITS TO A. DANNY YAISH D.O. FOR SERVICES RENDERED BY HIM OR OTHERS UNDER HIS SUPERVISION. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THESE CHARGES AND/OR ANY BALANCE NOT COVERED BY MY INSURANCE. ***THERE IS A CHARGE FOR NOT SHOWING UP FOR SCHEDULED APPOINTMENTS. AFTER YOUR 2ND NO SHOW/NO CALL YOUR ACCOUNT WILL BE CHARGED $25.00 AND POTENTIALLY YOU MAY BE DROPPED AS A PATIENT.*** I HAVE READ THIS AGREEMENT AND HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS WHICH WERE ANSWERED TO MY SATISFACTION.

PATIENT/AUTHORIZED PERSON'S SIGNATURE_____

PRINT NAME_____ DATE_____

RELATIONSHIP TO PATIENT_____

(6/11/2012)