Hussam Kujok, M.D., Inc.

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Date _____ Home Phone _____ Cell Phone _____

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____ Driver Lic. # _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ Race _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

In case of emergency who should be notified? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ Soc. Sec. # _____

Group # _____ Subscriber # _____

ASSIGNMENT AND RELEASE

The above information is true to the best of my knowledge.

Authorizations:

1. Authorization for Treatment: I authorize any medical treatment, anesthetics or surgical procedures as the attending physician deems necessary.
2. Authorization to Release: I herby authorize the clinic and it's attending physicians to release any information acquired in the course of my examination.
3. Statement of Financial Responsibility: I understand that I am responsible for payment of charges incurred in the course of treatment.
4. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance.
5. I authorize Hussam Kujok, MD, Inc. or insurance company to release any information required to process my claims.
6. I have received, read and understand Hussam Kujok, MD, Inc. Notice of Privacy Practice.

Patient/Guardian Signature _____ Date _____