

# Azar/Filipov, MD, PA

**Please Print Clearly**

## ■ Patient Information

Name (Last, First, Middle) \_\_\_\_\_ Today's Date \_\_\_\_\_  
Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Home Phone \_\_\_\_\_  
Email address \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Address \_\_\_\_\_ Work Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Sex:  M  F  
 Check if Minor (less than 18) Marital Status:  Single  Married  Divorced  Widowed  Separated  
If under 18, list parents or guardians' names \_\_\_\_\_  
Person to contact if unable to reach you & phone # \_\_\_\_\_  
Person responsible for bills \_\_\_\_\_  
Referring Physician \_\_\_\_\_ Phone \_\_\_\_\_

## ■ Primary Insurance

Insurance Company \_\_\_\_\_  
Insurance ID # \_\_\_\_\_ Group # \_\_\_\_\_  
*Please enter the policyholder's information below. If you are the policyholder yourself, check this box  and skip to the next section.*  
Policyholder's Name (Last, First, Middle) \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_

## ■ Secondary Insurance (If not applicable, please cross out section. If you have tertiary insurance, please ask the receptionist for another page.)

Insurance Company \_\_\_\_\_  
Insurance ID # \_\_\_\_\_ Group # \_\_\_\_\_  
*Please enter the policyholder's information below. If you are the policyholder yourself, check this box  and skip to the next section.*  
Policyholder's Name (Last, First, Middle) \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_

## ■ Is today's visit related to an accident?

Yes  No If yes, what type of accident (Auto, Employment, Other) \_\_\_\_\_  
When did the accident occur? Date and Time \_\_\_\_\_

## ■ Assignment and Release

I hereby authorize payment directly to Azar/Filipov, MD, PA of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered for me or for my dependents. I authorize the doctors and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place of the original. I have read and agreed to the above.

## ■ Consent

**I consent to and authorize the administration of all routine office care; the performance of all examinations; diagnostic procedures and medical treatment, which judgment of my attending physician(s) may be necessary or desirable for my medical care.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Account #: \_\_\_\_\_