HEALTH First
MEDICAL CENTER
Syed F. Hussain M.D.

Patient Registration Form

Patient Last Name _____ First Name_____

Male _____ Female _____ DOB _____/_____/_____

Social Security _____

Marital Status: _ Single _ Married _ Divorced _ Widowed Age _____

Address _____

City _____State _____ Zip _____

Home Phone _____

Cell Phone _____

Work Phone _____

Employer _____

Occupation _____

Address_____

City _____State _____ Zip_____

Spouse's Name & Address_____

City _____

State _____ Zip _____

DOB _____/_____/_____

Social Security _____

Home Phone _____

Cell Phone _____

Work Phone _____

Employer _____

Occupation _____

Address_____

City _____ State_____ Zip_____

Primary Insured Information

Guarantor Name_____

Relationship_____

Address_____

City_____ State_____Zip_____

Home Phone_____ Work Phone_____

Employer_____ Occupation_____

Insurance Company Name_____

Policy ID#_____ Group#_____

Effective Date____/_____/_____

Secondary Insured Information

Guarantor Name_____

Relationship_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone_____

Employer_____ Occupation_____

Insurance Company Name_____

Policy ID#_____ Group#_____

Effective Date____/_____/_____

I hereby authorize release of information necessary to file a claim with my insurance company. I assign benefits to be paid to Health First Medical Center and I understand that I am financially responsible for charges for medical services rendered to theabove named patient regardless of insurance coverage, including amount not limited to any and all immunizations. In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due.

Patient or Guarantor Signature_____

Date_____/_____/_____