MEHDI BAJOGHLI, M.D., P.C.

DATE: _____

PATIENT INFORMATION

NAME: _____
(Last) (First) (MI)

Address: _____
(Street Address) (Town/City) (State) (Zip)

Home Telephone No: _____ **Cell Phone No**: _____

Social Security #: _____ **Email**: _____

Date of Birth: ____/____/____ **Age**: _____ **Sex**: Male ___ Female ___ **Marital Status**: ___Single ___ Married ___ Other

Is patient employed? : YES NO (Please Circle) If employed, please fill out the following:

Name of Employer: _____

Employer Phone No: _____ **Employer Address**: _____

ADDITIONAL INFORMATION

1. Name of PRIMARY CARE PHYSICIAN: _____

   Phone: _____ Address: _____

2. How did you hear about us? PLEASE Circle ALL that apply:

   a. Insurance Company Website or Directory

   b. Friend/ Relative/ Colleague _____

   c. Doctor's Name: _____

   d. Yellow Pages (Verizon/Yellow Book/ Local-Community Book)

   e. Google Search/ Internet/ Website name: _____

   f. Other: _____

3. <u>Name of parents or guardian (if patient is child):</u>

   Father: _____ SS#: _____

   Mother:_____ SS#:_____

4. <u>Emergency Contact:</u>

   Name:_____

   Relation to patient:_____

   Phone Number:_____

PLEASE TURN OVER.

MEHDI BAJOGHLI, M.D., P.C.

PRIMARY Insurance Information

Name of Policy Holder: _____

Date of Birth of Policy Holder: ___/___/____ Social Security No. of Policy Holder: ____-____-_____

Name of Primary Insurance: _____ ID #: _____

Primary Insurance Co. Phone No: _____

Address: _____
(Street/ PO Box) (Town/City) (State) (Zip Code)

Relationship of Patient to Policyholder: ___Self ___Spouse ___Child ___ Parent

SECONDARY Insurance Information

Name of Policy Holder: _____

Date of Birth of Policy Holder: ___/___/____ Social Security No. of Policy Holder: ____-____-_____

Name of Secondary Insurance: _____ ID #: _____

Secondary Insurance Co. Phone No: _____

Address: _____
(Street/ PO Box) (Town/City) (State) (Zip Code)

Relationship of Patient to Policyholder: ___Self ___Spouse ___Child ___ Parent

Assignment & Release

FOR PATIENTS UNDER EIGHTEEN (18) years of age:

I hereby authorize Dr. Bajoghli and his staff to perform skin test and to administer hyposensitization (allergy injections) to _____
(Name of Child)

And render any emergency treatments deemed necessary, if he/she should be brought to this office by anyone other than myself.

X_____ _____
Signature of Patient, Parent or Guardian Date

_____
Please Print Name