

*MARWAN M. SHAYKH, M.D.*

**PATIENT INFORMATION SHEET**

TODAY'S DATE \_\_\_\_\_

PATIENT NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

SOCIAL SECURITY NO. \_\_\_\_\_ DRIVER'S LICENSE NO. \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

PRIMARY CARE PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

REFERRED BY \_\_\_\_\_ PHONE \_\_\_\_\_

SPOUSE/PARTNER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

SOCIAL SECURITY NO. \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_

\*\*\*\*\*

PRIMARY INSURANCE CO. NAME \_\_\_\_\_ PHONE \_\_\_\_\_

NAME OF POLICYHOLDER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

MEMBER ID# \_\_\_\_\_ GROUP# \_\_\_\_\_

SECONDARY INSURANCE CO. NAME \_\_\_\_\_ PHONE \_\_\_\_\_

NAME OF POLICYHOLDER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

MEMBER ID# \_\_\_\_\_ GROUP# \_\_\_\_\_

I CONSENT TO THE USE OR DISCLOSURE OF MY PROTECTED HEALTH INFORMATION BY DR. SHAYKH FOR THE PURPOSE OF: OBTAINING CLAIM PAYMENT, PROVIDING MEDICAL TREATMENT OR TO CONDUCT HEALTH CARE OPERATIONS. I UNDERSTAND THAT THIS INFORMATION MUST BE UPDATED ON AN ANNUAL BASIS AND IS TRUE AND CORRECT TO MY KNOWLEDGE. I ALSO UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS CONSENT, IN WRITING, AT ANY TIME, EXCEPT TO THE EXTENT THAT IT AFFECTS THE QUALITY OF CARE THAT IS PROVIDED BY DR. SHAYKH. FURTHERMORE, I AGREE TO BE FULLY RESPONSIBLE FOR ALL LAWFUL DEBTS INCURRED BY MYSELF FOR SERVICES RENDERED BY DR. SHAYKH, WHETHER COVERED BY MY INSURANCE COMPANY OR NOT.

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_