

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 _____