Yazen Joudeh, MD -- Patient Information Form

Patient Name: (Last)_____(First)_____(MI)___

Home Phone: _____Cellular: _____Work:_____

Email address (so you can receive notifications & communicate with us via our Patient Portal:www.onpatient.com)

_____

Preferred Communication: Circle-Home, Cell, Work, Email, Mail)

Medication History Consent: To best manage your health & medications, we may access your pharmacy/ medication history. Please circle one: **I consent** to medication history or **I do not consent** to medication history.

SSN: _____-___-____Birthdate: _____Age: _____Sex: M F

Race_____ Preferred Language: English Arabic Spanish Other:_____

Patient Address: _____

City: _____ State: _____ Zip: _____

Marital Status: Single Married Divorced Widow(er)

In Case of Emergency:

Name: _____Relationship: _____ Phone: _____

Patient's Spouse: _____ Phone: _____

If a child, parent's name: _____ Phone: _____

Referred by: _____

Insurance:

Primary Insurance Company:_____ Seondary Insurance:_____

Address: _____ Secondary Address:_____

ID Number:_____ Group Number_____ Secondary ID:_____Group #_____

Insurance Telephone: _____ Secondary Insurance Telephone:_____

If subscriber is **different** from patient, please give subscriber's name, DOB, SSN, & address below:

_____

Preferred Pharmacy: _____ Address (if known)_____ Phone #_____

Financial Policy & Assignment of Benefits & Treatment:

Thank you for selecting Dr. Joudeh for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Cash, credit card, and debit.

I hereby authorize the verification of my medical benefits & payments directly to the treating physician. I authorize the release of any information required in the course of my treatment to my insurance company. I understand I am responsible for any portion of my bill not covered by my insurance company. I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I also hereby consent and authorize the physician and any of his associates, assistants, or consultants to provide medical treatment for the above patient.

I have read and understand all of the above and have agreed to these statements.

_____ _____

Patient's Signature Date