KAMRAN KHAZAEI, MD

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HIPAA & REGISTRATION UPDATE FORM

Date: / /	Primary Care Phys. (PCP):	PCP Phone No:

PATIENT INFORMATION

Patients Last Name: First: Middle:	Gender: F / M	Marital Status (circle one): Single/Mar/Div/Sep/Widow

Birth Date: / /	Age:	Social Security No: - -	Home Phone No: ( )	Cell Phone No: ( )

Street Address:	City:	State:	Zip Code:

Race: Ethnicity: Preferred Language:

0 Decline to specify:

PHARMACY INFORMATION

Local Pharmacy & Phone No:	Address:	City:	State:
Mail-Order Pharmacy & Phone No:	Address:	City:	State:

INSURANCE INFORMATION

Please give your insurance card(s) & driver's license to the receptionist.

Name of Primary Insurance Co.:	Subscriber's Name:	Subscriber's SSN: / /	Subscriber's Date of Birth: / /

Patient's relationship to subscriber: □ Self □ Spouse □ Child □ Partner □ Other – please explain:

Name of Secondary Insurance Co.:	Subscriber's Name:	Subscriber's SSN: / /	Subscriber's Date of Birth: / /

Patient's relationship to subscriber: □ Self □ Spouse □ Child □ Partner □ Other – please explain:

IN CASE OF EMERGENCY

Name of Contact:	Relationship to patient:	Home Phone No.: ( ) -	Cell Phone No: ( ) -

0 **I authorize the following individual(s) to receive information pertaining to any medical history, treatment received and billing matters:**

Name:	Relationship to patient:	Birth Date: / /	Contact Phone: □Home □Cell ( ) -

PATIENT PORTAL COMMUNICATION

We continue to offer secure electronic communications between you and our office via our Patient Portal. Secure Messages and information can only be read by someone who knows the right password to log in to the Portal site. The Communications are automatically encrypted and for those who want to participate, this secure communication can be a Valuable tool to provide administrative and clinical information provided that we maintain your most up-to-date Information.
Do you wish to either continue to participate or sign up to participate?

□ Yes, I want to participate, my email is:( )□No, I do not want to participate at this time.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize my provider or insurance company to release any information required to process my claims.

Patient Signature: **Date:**