James Kayvanfar, M.D.
Patient Registration Form

Today's Date:___/___/_____

Full Name (Last, First MI):_____ **Sex**: M F **Age**:_____ **Birth Date**:___/___/_____

Marital Status: S M D W Sep **Social Sec #**:_____-_____-_____ **Driver's Licence #**:_____

Home Tel #: (_____) _____-_____ **Work Tel #**: (_____) _____-_____X_____

Cell #: (_____) _____-_____ **Email Address:**_____

Home Address:_____ **City/State**:_____ **Zip**:_____

Occupation:_____ **Employer**:_____ **Nature of Business**:_____

Employer's Address:_____

Whom to Contact in Case of Emergency:_____ **Tel #**:(_____) _____-_____

Who Referred You Here?_____ **Family/Personal Physician & Tel #**:_____

If someone other than patient is responsible for payment, please complete: Name:_____

Relationship:_____ **Social Sec #**:_____-_____-_____ **Driver's Licence #**:_____

Address:_____ **Tel #**:(_____) _____-_____

Employer:_____ **Employer's Tel #**:(_____) _____-_____

If an ATTORNEY is handling your bills, please provide: Attorney's Name:_____

Address:_____ **Tel #**:(_____) _____-_____

Please Provide Copy of **Insurance Cards**:
Primary INSURANCE Name & Address:_____

ID #:_____ **Group #**:_____ **Insured's Name**:_____ **Insured's Sex**: M F

Insured's Birth Date:___/___/_____ **Insured's Social Sec #**:_____-_____-_____ **Insured's Tel #**:_____

Deductible Amount Per Year:$_____ **Have You Met Your Deductible This Year?** Yes / No

Your Co-Payment is:$_____ **Your Insurance Pays**: 70% 75% 80% 90% 100% Other:_____

If Insurance Through Employer, Please Indicate: Employer's Name:_____

Address:_____ **Tel #**:(_____) _____-_____

Secondary INSURANCE Name & Address:_____

ID #:_____ **Group #**:_____ **Insured's Name**:_____ **Insured's Sex**: M F

Insured's Birth Date:___/___/_____ **Insured's Social Sec #**:_____-_____-_____ **Insured's Tel #**:_____

If Insurance Through Employer, Please Indicate: Employer's Name:_____

Address:_____ **Tel #**:(_____) _____-_____

I hereby assign to James Kayvanfar, M.D., all money to which I am entitled for medical expenses related to the professional services rendered but not to exceed my indebtness to Dr. Kayvanfar. I authorize release of information to my insurance companies & attorney. I direct my insurance companies & attorney to pay James Kayvanfar, M.D. directly for the professional services rendered. I understand that **payment for all professional services is solely my responsibility** & agree to pay my outstanding balance promptly. I will pay a monthly service charge equal to 1.5% of my outstanding balance, but no less than $4, for any balance outstanding more than 60 days from the date of service. I further agree that in the event of non-payment, I bear the cost of collection, court costs, and reasonable legal fees should this be required. I will pay a charge of $15 if my bank returns my check unpaid.

_____ _____ _____

Insured or Guardian's Signature **Patient's Signature** **Date**