DEMOGRAPHICS
(MUST BE FILLED OUT IN BLACK INK)

Name _____ Home # _____
FIRST MIDDLE LAST AREA CODE

Address _____ Work # _____
STREET OR PO BOX AREA CODE

_____ Cell # _____
CITY, STATE, AND ZIP CODE AREA CODE

DOB _____ Age _____ SSN# _____ M ____ F ____ Marital Status: S M D W

Primary Care Physician: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

Emergency Contact Name: _____ Phone #: _____

Pharmacy: _____ Pharmacy Phone#: _____

Do you wear glasses? Yes _____ No _____ Do you wear contacts? Yes _____ No _____

Please State Your Current Employer, Student or Retired: _____

Race (PLEASE CIRCLE): White – Hispanic – Black/African American – Native Hawaiian/other Pacific – Asian American Indian/Alaska Native – Other Race – Other Pacific Islander

Language Spoken: _____ Ethnicity: _____

INSURANCE INFORMATION

PLEASE FILL OUT IF YOU ARE **NOT** THE PRIMARY POLICY HOLDER – WE WILL PHOTOCOPY ALL CARDS

Primary Insurance: _____ ID#: _____ Group#: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder SSN: _____ Relationship to Patient: _____

Secondary Insurance: _____ ID#: _____ Group#: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder SSN: _____ Relationship to Patient: _____

PLEASE READ AND SIGN THE FOLLOWING STATEMENTS:

I authorize the release of medical information necessary to process an insurance claim.
I authorize payment of medical benefits directly to Kayvan Keyhani, M.D.
I understand I am financially responsible for any balance not covered by any insurance carrier.

_____ _____ _____
PATIENT SIGNATURE (Please sign in black ink) RELATIONSHIP TO PATIENT IF UNDER 18 DATE