DEMOGRAPHICS

Email: ____

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 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