Serenity Plastic Surgery
Ali Sajjadian, M.D.

PATIENT INFORMATION

NAME _____ Birth date: ___/___/___ Age :_____ Sex: M / F
LAST FIRST MIDDLE INITIAL

HOME ADDRESS _____
STREET CITY STATE ZIP

E MAIL ADDRESS _____

WORK TELEPHONE_____ HOME PHONE _____ CELL PHONE_____

BEST PHONE _____ **PREFERED CONTACT METHOD**_____ **MAIL OKAY? YES / NO**

EMPLOYER _____ OCCUPATION _____

SOCIAL SECURITY # _____DRIVERS LICENSE # _____

MARITAL STATUS: **M S W D** NAME OF SPOUSE _____DOB _____ S/S# _____

REASON FOR VISIT_____

_____

REFERRED BY: _____ PRIMARY CARE DOCTOR _____

NEAREST RELATIVE _____RELATIONSHIP _____PHONE # _____

EMERGENCY CONTACT _____ RELATIONSHIP _____PHONE # _____

INSURANCE INFORMATION

THIS OFFICE IS NOT A CONTRACTED PROVIDER

INSURANCE COMPANY _____

ID# _____GROUP/CLAIM/AUTH #_____

CLAIMS NAME &ADDRESS _____

_____

CLAIMS ADJUSTER _____ PHONE # _____

SUBSCRIBER'S NAME IF DIFFERENT_____

I HEREBY AUT HORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY MEDICAL CLAIM. I AUTHORIZE PAYMENT OF MEDICAL AND SURGICAL BENEFITS DIRECTLY TO ALI SAJJADIAN, M. D., HOWEVER, I ACCEPT FINANCIAL RESPONSIBILITY FOR CHARGES NOT COVERED BY MY INSURANCE OR THIS AUTH ORIZATION. I AL SO A UTHORIZE TH AT A PHOTOGRAPHIC COPY OF THIS DOCUMENT IS AS IF SUCH COPY WERE THE ORIGINAL. A FINANCE CHARGE MAY BE ASSESSED ON THE UNPAID BALANCE FOR ALL ACCOUNTS 90 DAYS PAST DUE. ** I ALSO UNDERSTAND THAT DR. SAJJADIAN IS NOT A PREF ERED PROVIDER UN DER MY INSURANCE PLAN.

DATE _____ SIGNED _____

RELATIONSHIP IF PARENT OR GUARDIAN_____

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