GHADA Y. AFIFI, MD, INC.

(949) 718-6900

Patient Information as of ________________ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name ______________________________
First Middle Last

Address ______________________________
Street & Apt # City State Zip

Home Phone __________ Cell Phone __________ Other Phone __________

Any restrictions for contacting you? ❒ No ❒ Yes E-mail __________

Contact Restrictions: __________

Age ______ Birthdate __________ SS# __________ Gender ❒ Female ❒ Male

Marital Status ❒ Single ❒ Married to: __________ ❒ Other: __________

Patient's Employer __________ Occupation __________

Work Phone __________ Ext: ______ Is it okay to call you at work? ❒ Yes ❒ No

Address ______________________________
Street & Suite # City State Zip

How did you hear about us? (Mark all that apply)

❒ TV News ❒ TV Ad ❒ Phone Book ❒ Magazine ❒ Newsletter ❒ Seminar ❒ Salon ❒ Web

❒ Friend/Relative: __________ ❒ Doctor: __________ ❒ Other: __________

If you were referred by a specific person, may we thank them? ❒ Yes ❒ No

Emergency Contact
(Not in your household) __________ Relationship to Patient __________

Home Phone __________ Work Phone __________ Other Phone __________

Primary Health Insurance Company __________

Policy # __________ Group # __________ Ins. Phone __________

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ ______

Insured: Name __________ DOB __________ Employer __________

Secondary Health Insurance Company __________

Policy # __________ Group # __________ Ins. Phone __________

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ ______

Insured: Name __________ DOB __________ Employer __________

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Afifi to bill my insurance company for medically necessary services. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Ghada Y. Afifi, MD and myself.

Signature ______________________________ **Date** __________