# Nahid Hamoui, M.D. Inc.

**PATIENT INFORMATION:** (Please Print)

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐Separated ☐ Widowed

Patients Name: _____ ☐ Male ☐ Female
Last First Middle

Social Security #: _____ Date of Birth: _____ Age: _____

Address: _____
City State Zip Code

Home Phone: _____ Mobile Phone: _____

**DOCTORS:**

Referring: _____ Office Phone: _____

Primary (General): _____ Office Phone: _____

**PHARMACY INFORMATION:**

Name: _____ Store Phone: _____

**EMPLOYER INFORMATION:**

Company: _____ Occupation: _____

Address:_____
City State Zip Code

Work Phone: _____ Ext: _____ Can you receive calls? ☐ Yes ☐ No

**EMERGENCY CONTACT:**

Name: _____ Relationship: _____

Home Phone: _____ Mobile Phone: _____

**INSURANCE INFORMATION:** (Although we make photo copy of your card, we still need you to complete.)

How do you plan to pay for services? ☐ Insurance ☐ Cash

Primary Insurance: _____ Secondary Insurance: _____

Phone Number: _____ Co-Payment Amount: _____

ID Number: _____ Group Number: _____

**ASSIGNMENT OF BENEFITS:**

The above information is true to the best of my knowledge. I hereby authorize my insurance benefits to be directly Nahid Hamoui, MD. Inc. I understand that I am financially responsibility for non-covered services and balance. I also authorize Nahid Hamoui or my insurance company to release any information required to process my claim.

_____ _____
Patient or Guardian Signature Date