Khair Family Practice
125 Eagle Spring Drive
Stockbridge, GA 30281
Phone 770-213-3366
Fax 855-516-2317

Khair Family Practice

Sam Khair, MD

Patient Registration

PATIENT:

Last Name:_____First Name:_____Initial:_____

Address:_____Email:_____

City:_____State:_____Zip:_____Marital Status: M/S/D/W

Social Security Number:_____Birth Date:_____Gender: M/F Race:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Employer Name:_____Address:_____

Pharmacy Name:_____Phone #:_____

Pharmacy Cross Streets:_____

RESPONSIBLE PARTY:

Last Name:_____First Name:_____Initial:_____

Address:_____Apt. Or Space#:_____

City:_____State:_____Zip:_____Relationship to Patient:_____

Social Security Number:_____Birth Date:_____Gender: M/F

Home Phone:_____Cell Phone:_____Work Phone:_____

Employer Name:_____Address:_____

EMERGENCY CONTACT:

Full Name:_____ Relationship:_____

Telephone:_____

INSURANCE INFORMATION:

Primary Insurance:_____ Secondary Insurance:_____

Address:_____ Address:_____

City/State/Zip:_____ City/State/Zip:_____

Telephone:_____ Telephone:_____

Insured ID #:_____ Insured ID #:_____

Group #: _____ Group #: _____

Policy Owner Name:_____ Policy Owner Name:_____

DOB:_____Relationship:_____ DOB:_____Relationship:_____

Policy Owner Social Security #:_____ Policy Owner Social Security #:_____

Employer Name:_____ Employer Name:_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF MEDICAL BENEFITS:

I hereby authorize Khair Family Practice to treat the above named patient. I authorize the release of medical information necessary file Insurance claims in accordance with HIPAA guidelines. Photocopies are valid as original. I authorize payment of medical benefits to be paid directly to Khair Family Practice. I understand that I am financially responsible for any amounts not covered by my health insurance. I hereby consent the clinical staff of Khair Family Practice to view my medication history from external sources.

Signature:_ _____ Date:_____