ZAHIR YOUSAF, MD., F.C.C.P
PULMONARY & SLEEP MEDICINE

PATIENT REGISTRATION FORM

Today's date: _________ **Patient Name:** ____
First Middle Last Suffix

Physical Address: ____
Number/Street City State Zip

Mailing Address: ____
Number/Street City State Zip

Home Phone: (_____) _____-______ **Work Phone** (_____) _____-______ **Cell Phone:** _____________________

Date of Birth: ____/____/______ **Social Security #:** _____-____-______ **Sex:** M F

Race: American Indian/Alaskan Native Asian African-American Caucasian Pacific Islander Other Decline

Ethnicity: Hispanic Non-Hispanic Declined **Language:** ____________ **E-Mail:** ________________________

Marital Status: S M W D

Employer: ____________________ **Address:**____

Occupation: ______________________ **REFERRED BY:** Dr. ___________________

If you were not referred by a doctor, how did you hear about us? (i.e.- neighbor, friend, phonebook, internet, etc.; please provide a name) _____________________ Reason for Visit (i.e. symptoms): _________________________________

Primary Insurance

Insurance Name: __________________________________

Insurance Address: ________________________________

*ID#:*____

Group #: ____

Subscriber Name: _________________________________

Subscriber Relationship: *SELF* *SPOUSE* *PARENT*

Subscriber Employer: _______________________________

Address: _________________________________

____

Subscriber Date of Birth: ____/_____/_______

Secondary Insurance

Insurance Name: ______________________________

Insurance Address: ____________________________

ID#: ____

Group #: _____________________________________

Subscriber Name: ______________________________

Subscriber Relationship: *SELF* *SPOUSE* *PARENT*

Subscriber Employer: ___________________________

Address: ____________________________

____

Subscriber Date of Birth: ____/_____/______

PATIENT PAYMENT AUTHORIZATION:

I, ________________________________ hereby authorize Zahir Yousaf, M.D., to apply for benefits on my behalf for services rendered. I request payment from my health insurance carrier(s) to be made directly to Zahir Yousaf, M.D. I further authorize the release of any necessary information (including medical record information) for this or any related claim to my health insurance carrier(s). I certify that the information I have reported with regard to my insurance coverage is correct to the best of my knowledge. I permit a copy of this authorization to be used in place of the original.

I understand that I am personally financially responsible for any amount not covered by my health insurance carrier(s). I am responsible for all co-payments at the time of service. I am also responsible for all deductibles. If we do not participate with your insurance plan, payment is expected at the time of service. I agree to promptly pay all charges when billed for medical services rendered and accept legal responsibility for any and all charges for the patient named above. Your signature below signifies your understand and agreement with these policies.

____ ______________________________

PATIENT (or Representative's) SIGNATURE **DATE**