

**NEVADA MEDICAL CLINIC**

**PATIENT INFORMATION SHEET**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Patient's Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Circle One: Male/Female

Driver's License # \_\_\_\_\_  
(Copy of current valid Government issued ID required)

Employer's Name: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Employer's Telephone#: \_\_\_\_\_ Department: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Contact's # \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

INSURANCE: PLEASE LIST ALL INSURANCE COMPANIES YOU BELONG TO: (copy of Insurance cards required)

PRIMARY: Name: \_\_\_\_\_ Policy # \_\_\_\_\_

Subscriber: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

SECONDARY: Name: \_\_\_\_\_ Policy # \_\_\_\_\_

Subscriber: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

MEDICARE # \_\_\_\_\_ ( Please Include Letter/card copy)

MEDICAID # \_\_\_\_\_

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**ASSIGNMENT OF BENEFITS**

I HEREBY GUARANTEE PAYMENT OF ALL CHARGES INCURRED FOR THE ACCOUNT OF :

I HEREBY ASSIGN AND DIRECT TO PAY ANY AND ALL BENEFITS FOR MEDICAL SERVICES UNDER THIS CLAIM DIRECTLY TO FARRUKH IMTIAZ M.D. dba Nevada Medical Clinic I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION REQUESTED BY THE INSURANCE COMPANIES WITH THE ABOVE ASSIGNMENT AND ALLOW PRIOR AUTHORIZATION CHECK.

PATIENT SIGNATURE/RESPONSIBLE PARTY \_\_\_\_\_ DATE \_\_\_\_\_