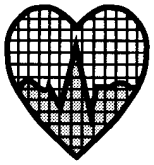

Khalid Shafiq, M.D., F.A.C.C.

Fellow of the American College of Cardiology
Diplomate American Board of Internal Medicine and Cardiovascular Disease
Diagnostic & Interventional Cardiology

PATIENT REGISTRATION

Name (Last) _____ (First) _____ (MI) ____
Address _____ City _____ State ____ Zip _____
Home Phone _____ Work Phone _____ Email _____
Dr. Lic. # _____ Soc. Sec. # _____ Birthdate _____
Sex ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Employer _____ Occupation _____
Business Address _____
Referring Physician _____
Next of Kin Name _____ Relationship _____
Address _____ Phone (H) _____ (W) _____

PRIMARY INSURANCE

Person Responsible for Account (Last Name) _____ (First) _____ (MI) ____
Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____
Address _____ Home Phone _____
City _____ State _____ Zip _____
Responsible Party Employed By _____ Business Phone _____
Business Address _____ Occupation _____
Insurance Company _____
Insurance Company Address _____
Subscriber I.D. # _____ Group # _____

ADDITIONAL INSURANCE (IF APPLICABLE)

Insured Name (Last) _____ (First) _____ (MI)____
Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____
Address _____ Home Phone _____
City _____ State _____ Zip _____
Insured Employed By _____ Business Phone _____
Insurance Company _____
Insurance Company Address _____
Subscriber I.D. # _____ Group # _____

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Dr. _____ all insurance benefits otherwise payable to me for services rendered. I udnerstand that I am financially responsible for all charges whether or not paid by insurance, for all services rendered on my behalf or my dependents.

I Authorize the above noted doctor and/or any provider or supplier of services in this office to release any information requested to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

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