### Naficy Medical Group

27512 Calle Arroyo Suite A

San Juan Capistrano, CA 92675

# Welcome!

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
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| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient’s last name: | | | | | | | | | First: | | | | | | Middle: | | | ❑ Mr.  ❑ Mrs. | | | ❑ Miss  ❑ Ms. | Marital status (circle one) | | | | | | |
|  | | | | | | | | | | | | | | | | | | Single / Mar / Div / Sep / Wid | | | | | | |
| Is this your legal name? | | | | Ethnicity: | | | | | | | Language Best Spoken: | | | | | | | | | Birth date: | | | | Age: | Sex: | | | |
| ❑ Yes | | ❑ No | |  | | | | | | |  | | | | | | | | | / / | | | |  | ❑ M | | ❑ F | |
| Street address: | | | | | | | | | | | | | | | | Social Security no.: | | | | | | Home phone no.: | | | | | | |
|  | | | | | | | | | | | | | | | |  | | | | | | ( ) | | | | | | |
| Cell Phone No.: | | | | | | | | City: | | | | | | | | | | State: | | | | | ZIP Code: | | | | | |
| ( ) | | | | | | | |  | | | | | | | | | |  | | | | |  | | | | | |
| Occupation: | | | | | | | | Employer: | | | | | | | | | | | | | | Employer phone no.: | | | | | | |
|  | | | | | | | |  | | | | | | | | | | | | | | ( ) | | | | | | |
| Chose clinic because/Referred to clinic by (please check one box): | | | | | | | | | | | | | | ❑ Dr. | | |  | | | | | ❑ Insurance Plan | | | | ❑ Hospital | | |
| ❑ Family | | | ❑ Friend | | ❑ Close to home/work | | | | | | | ❑ Other | | | | | | E-MAIL Address: | | |  | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| INSURANCE INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is this patient covered by insurance? | | | | | | | ❑ Yes | | | ❑ No | |  | | | | | | | | | | | | | | | | |
| Please indicate primary insurance: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| IN CASE OF EMERGENCY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of local friend or relative (not living at same address): | | | | | | | | | | | | | Relationship to patient: | | | | | | | | Home phone no.: | | | Cell phone no.: | | | | |
|  | | | | | | | | | | | | |  | | | | | | | | ( ) | | | ( ) | | | | |
| I hereby give lifetime authorization for payment of insurance benefits to be made directly to K. Mitchell Naficy M.D. INC. and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney’s fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | |  |  | | | | | | | | |  |
|  | Patient/Guardian signature | | | | | | | | | | | | | | | | |  | Date | | | | | | | | |  |