### Naficy Medical Group

27512 Calle Arroyo Suite A

San Juan Capistrano, CA 92675

# Welcome!

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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 |  |