**Yazen Joudeh, MD - Patient Information Form**

Patient Name: (Last) (First) (MI)\_\_\_\_

Home Phone: Cellular: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email Address** (so you can receive notifications & communicate with us via our Patient Portal ([www.onpatient.com](http://www.onpatient.com)) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Communication: Please Circle - Home, Cell, Work, Email

**Medication History Consent**: To best manage your health & medications, may we access your pharmacy for your medication history? Please circle one: **I consent** or **I do not consent**

**SSN**: \_\_\_\_\_-\_\_\_-\_\_\_\_**Birthdate**: **Age**: **Sex**: M F

Race\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Language: English Arabic Spanish Other: \_\_\_\_\_\_\_\_\_\_

**Patient Address**:

**City**: **State**: **Zip**:

**Marital Status**: Single Married Divorced Widowed

**In Case of Emergency:**

Name: Relationship: Phone:

Patient’s Spouse: Phone:

If a child, parent’s name: Phone:

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance**:

Primary Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group # \_\_\_\_\_\_\_\_\_\_\_\_ Secondary ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_

Insurance Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Insurance Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If subscriber is **different** from patient, please give subscriber’s name, DOB, SSN, & address below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Pharmacy:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address (if known)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_

**Financial Policy & Assignment of Benefits & Treatment:**

Thank you for selecting Dr. Joudeh for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Cash, credit card, and debit.

I hereby authorize the verification of my medical benefits & payments directly to the treating physician. I authorize the release of any information required in the course of my treatment to my insurance company. I understand I am responsible for any portion of my bill not covered by my insurance company. I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney’s fees and court costs.

I also hereby consent and authorize the physician and any of his associates, assistants, or consultants to provide medical treatment for the above patient.

I have read and understand all of the above and have agreed to these statements.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature Date