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Infectious Disease SPECIALISTS

- Jawad Nazir, MD
- Fares Masannat, MD
- Brian Pepito, MD
- Robert Kessler, MD
- Asma Syed, MD

NEW PATIENT INFORMATION

PATIENT _____

Address _____
CITY STATE ZIP

Home Phone _____ Cell _____ Business Phone _____

Employer _____ Occupation _____

Social Security No. _____ Date of Birth _____ Sex _____ Age _____

Marital Status ☐ S ☐ M ☐ W ☐ D

REFERRING DOCTOR: _____ **FAMILY DOCTOR:** _____

Person Responsible for Payment: **(If other than patient)** _____

Address _____
CITY STATE ZIP

Home Phone _____ Work Phone _____

Social Security No. _____ Date of Birth _____

WHO SHOULD WE CONTACT IN CASE OF EMERGENCY _____

Address _____
CITY STATE ZIP

Home Phone _____ Work Phone _____

INSURANCE INFORMATION

IS THIS A WORK RELATED INJURY VISIT? ☐ YES ☐ NO WORKMAN'S COMP ☐ YES ☐ NO

Primary Insurance _____	Secondary Insurance _____
Address _____	Address _____
City, State, Zip _____	City, State, Zip _____
Name of Policy Holder _____	Name of Policy Holder _____
Policy Holder Birthdate _____	Policy Holder Birthdate _____
Policy ID Number _____	Policy ID Number _____
Group ID Number _____	Group ID Number _____

AUTHORIZATION TREATMENT: Realizing that I require medical care, I do hereby voluntarily consent to such medical care encompassing such diagnostic and medical treatment by my physician his assistants, or his designees including consulting physicians, employees, and students in educational programs affiliated with Infectious Disease Specialists, as is necessary in the judgment of my physician. I consent to testing for HIV (AIDS) and or Hepatitis should a health care worker have accidental exposure to my blood or other body substances.

RELEASE OF INFORMATION: I hereby authorize Infectious Disease Specialists release diagnostic and procedural information for the completion of insurance claim forms. I hereby authorize the release of clinical information to the third party payers and/or their reviewing contractors to comply with preadmissions review and continued stay requirements. I authorize the release of clinical information to referring physicians and facilities for the purpose of continued health care.

ASSIGNMENT OF BENEFITS: Authorization is hereby granted for the direct payment to Infectious Disease Specialists for all benefits payable to me. I understand I am financially responsible for all charges regardless of insurance coverage.

Patient/Guardian/POA Signature: _____ **Date:** _____

Date: _____ Initial: _____	Date: _____ Initial: _____	Date: _____ Initial: _____
Date: _____ Initial: _____	Date: _____ Initial: _____	Date: _____ Initial: _____
Date: _____ Initial: _____	Date: _____ Initial: _____	Date: _____ Initial: _____