AMIR SALIM, M.D. P.A.

NEW PATIENT REGISTRATION

Date:___________

Patient Name: Last_________________ First_________________ Middle________________

Patient Birthday:___________ Gender: M F SSN:_______-_______-________

Marital Status:__________________________ Occupation:__________________________

Phone Home________________ Work_________________ Cell_____________________

Address:____

City _____________________________ Zip ____

Name of Insurance Policy Holder: Last_______________ First_______________ MI_________

Relationship of Patient to Policy Holder: ____

Policy Holder Birthday: _____________________Policy Holder SSN:______-________-______

Policy Holder Address (if different): ____

Name of Insured Employer: ____

Insurance Name:____

Policy ID Number:________________________ Group Number:_________________________

How did you hear about us? ____

Emergency Contact Person: Last________________________ First_______________________

Phone ___________________________ Alternate number ____________________________

Relationship of this person to Patient____

Local pharmacy where we can call in your prescription when needed______________________

Pharmacy Location: ____________________________________Phone:___________________

Do you have Advance Directive to Physicians? Y N (If yes, please provide us with a copy)

Email:____

****

Patient Signature: ____

Name of Person who fills out this form, if not Patient: __________________________________

Signature of Person who fills out this form, if not Patient ________________________________

Relationship of Person who fills out this form to Patient ________________________________

(rev 10/06)