

Richard S. Obedian M.D., F.A.A.O.S., PLLC

Patient Intake Sheet

Name: _____

Address: _____

Date of Birth: _____ Male Female

Social Security No.: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Marital Status: M S D W

Occupation: _____

EMERGENCY CONTACT

Name: _____

Phone: _____

Relationship: _____

RESPONSIBLE PARTY'S EMPLOYER INFORMATION

Name: _____

Address: _____

Phone: _____

PATIENT'S PERSONAL PHYSICIAN

Name: _____

Address: _____

Phone: _____

REFERRING PERSON

Name: _____

PHARMACY: _____

Address: _____

Reason for Visit: _____

Should this injury be filed under no fault
insurance or worker's compensation?

Yes No

Primary Insurance Information:

Policy Holder _____

Policy Holder's Social: _____

Date of Birth: _____

Relationship to Patient: _____

Name of Insurance: _____

Address: _____

ID No: _____

Group No: _____

Secondary Insurance Information:

Policy Holder _____

Policy Holder's Social: _____

Date of Birth: _____

Relationship to Patient: _____

Name of Insurance: _____

Address: _____

ID No: _____

Group No: _____

Phone: _____

Fax: _____

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"I verify the accuracy of the above information and I authorize the release of information as provided on this form. I also authorize the assignment of benefits directly to Richard S. Obedian, M.D. I understand that I am financially responsible for the treatment rendered. I hereby authorize Richard S. Obedian, M.D. to submit a claim to the insurance carrier or its intermediaries for all covered services rendered for radiology and orthopaedic care and authorize and direct the insurance carrier or its intermediaries to issue payment check(s) directly to Richard S. Obedian, M.D."

SIGNATURE _____

DATE: _____