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:_____

REFERRING PERSON:
Name:_____ `

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:_____

"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., PLLC. I understand that I am financially responsible for the treatment rendered. I hereby authorize Richard S. Obedian, M.D., PLLC 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., PLLC"

SIGNATURE_____ **DATE:**_____