SHIRAZ H. KASSAM, M.D.

OBSTETRICS & GYNECOLOGY
1380 MILSTEAD AVE, STE. B
CONYERS, GA. 30012
PHONE:(770) 922-2424/FAX: (770) 922-8782

Date______________

Patient's Name____ Social Security #___________________

Date of Birth_____________________ Age__________________ Marital Status: S M W D

Home Address ____

City ______________________ State ________________ Zip Code ________ County ________________

Home Phone _______________________ Cell Phone ________________________________

Employers Name & Address ____

Work Phone Number _______________________ Occupation _____________________ Yrs Employed ____

Spouse or Parent's Name _____________________ Spouse's DOB ______________ Spouse's SS# _____________

Spouse or Parent's Employer ______________________________ Phone Number ________________________

Emergency Contact Person _____________________________ Contact Phone Number ____________________

Emergency Contact Address ____

Known Drug Allergies ___________________________________

Family Physician & Phone Number ____

Referred By: ____

ALL CHARGES OR COPAYS ARE DUE AT THE TIME OF SERVICE. PATIENT IS RESPONSIBLE FOR FURNISHING CURRENT INSURANCE INFORMATION AT THE TIME OF SERVICE TO INSURE PROPER BILLING. IT IS THE PATIENT'S RESPONSIBILITY TO BE AWARE OF COVERAGE INFORMATION ON THEIR INSURANCE POLICY. IF YOU HAVE A QUESTION ABOUT COVERAGE OF A SERVICE PLEASE REFER TO YOUR INSURANCE POLICY OR INSURANCE AGENT BEFORE SERVICE IS RENDERED.

PRIMARY INSURANCE NAME__________________________ **POLICY #** ____________________ **GROUP#**_____________

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ALL PROFESSIONAL SERVICES RENDERED WILL BE FILED WITH YOUR INSURANCE COMPANY. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE.

INSURANCE AUTHORIZATION ASSIGNMENT
I HEREBY AUTHORIZE DR. SHIRAZ H. KASSAM TO FURNISH INFORMATION TO MY INSURANCE CARRIER CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO DR. SHIRAZ H. KASSAM ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO ME OR MY DEPENDENTS.
I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE.

DATE: ____________________________ **SIGNATURE:** ____