Jasmine Moghissi, M.D., P.C.

Master Registration

Patient Information

Name:_____
(last) (first) (middle initial)

Social Security Number _____ Sex: ☐ M ☐ F

Date of Birth _____

Marital Status _____

Emergency Contact _____ Phone _____

Current Address:

Street _____

City _____State _____Zip Code _____

Home Phone _____Work Phone _____

Guarantor Information if Patient is a Minor:

Name _____SS#_____DOB_____

Address_____

Home Phone_____Work Phone_____

Primary Insurance _____

Policy Holders Name_____SS#_____DOB_____

Employer_____

Secondary Insurance _____

Policy Holders Name _____SS#_____DOB_____

Employer_____

I understand that I am liable for any charges incurred at Jasmine Moghissi, MD PC. I will make prompt payment to Jasmine Moghissi, MD PC for any visit not covered by my insurance company. I understand that if my insurance dictates I must choose Jasmine Moghissi, MD as my primary care physician and that if I do not, I will be liable for the charges incurred. I authorize payment of benefits to Jasmine Moghissi, MD PC for services rendered and the release of medical information necessary to determine these benefits payable for related services. I understand my previous balances and all co-pays will be collected at the time of service. In the event my account becomes delinquent, it is my responsibility to pay the actual and reasonable collection agency and /or attorney's fees. It is my responsibility to pay a $25.00 late fee/ collection fee for accounts not paid in full within 60 days. If a check is declined or returned there is a $50.00 non-refundable fee.

_____ _____

(Signature) (Date)