Patients Profile **Farzad Forohar, M.D.**

Name:		Social Security:	
Date of Birth:		Referring Physician:	
Age:			
		Primary Physician:	
Address:			
		Patient's Employer:	
City, State and Zip:			

Phone: ( )	[ ] Home [ ] Work [ ] Mobile	Emergency Contact:	
Phone: ( )	[ ] Home [ ] Work [ ] Mobile	Relationship:	
Phone: ( )	[ ] Home [ ] Work [ ] Mobile	Phone:	

Primary Insurance Co:		Secondary Insurance Co:	
Policy Holder:		Policy Holder:	
Relationship:	Phone:	Relationship:	Phone:
ID #:	Group #:	ID #:	Group #:

Authorization to Release Information:

I hereby authorize the above named physician(s) to release any information in the course of my examination or treatment.

Date: ______________________ Signed: ____

Authorization to Pay:

I hereby authorize payment directly to the above-named physician(s) of surgical and/or medical benefits if any, otherwise payable to his/her/their services. I understand that I am financially responsible for the charges not covered by this agreement.

Date: _______________________ Signed: ____