

Northwest Endocrinology and Diabetes

Nihad Muhrez, M.D. Patient Information Form

Patient Name _____
Last First Middle Home Phone Cell Phone Work Phone

E-mail Address: _____

Address _____
Street City State Zip

Marital Status _____ Birth date _____ Age _____ Sex _____ Social Security # _____

Employer _____ Phone _____

Address _____
Street City State Zip

Spouse Name: _____ Work Phone: _____ Cell Phone: _____

Nearest Relative not living with you: _____ Phone: _____

Nearest Friend not living with you: _____ Phone: _____

Primary Care or Referring Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Whom may we contact in the case of an emergency: _____ Phone: _____

Whom may we thank for referring you to us: _____ Phone: _____

Who is responsible for this bill? _____

Insurance Information

#1 _____
Company Name Address City/State/Zip

Insured Name Policy Number/Group Number/ID Number/Account Number/Benefit Code

#2 _____
Company Name Address City/State/Zip

Insured Name

Policy Number/Group Number/ID Number/Account Number/Benefit Code

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature of Insured/Representative/Legal Guardian

Date