Darius J. Karimipour, M.D., P.C.
REGISTRATION FORM

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First Name:	Middle:

Social Security #	Email (for Portal Access):	Birth Date:	Age:	Sex: ❑ M ❑ F

Address:	Apt #	Home Phone #

City:	State:	ZIP Code:	Cell Phone #

Occupation:	Employer:	Employer phone #

*********How were you referred to us? ************	❑ Dr.	❑ Friend/Family	❑ Insurance Plan	❑ Hospital
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

Preferred Contact Method? Please Circle **Phone Email Portal Letter**	May we leave a voicemail if contacted by phone? Please Circle: **Yes or No**

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone #

Is this patient covered by insurance?	❑ Yes	❑ No

Insurance Name:	❑ Medicare	❑ BCBS	❑ Medicaid	❑ HAP	❑ Cofinity/PPOM	❑ Other ___________________________

Contract/Policy #:	Group #:

Subscriber's name:	Subscriber's S.S. #	Birth date:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Policy #	Group #

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone #:	Work phone #:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Darius J. Karimipour MD PC or insurance company to release any information required to process my claims.

Patient/Guardian signature	Date: