Hasbani & Hasbani Medical Group

Patient Registration

Patient Information

All fields in red must be filled out. If a question doesn't apply to you, please enter "NONE"

First Name | Last Name | Email

Preferred Name | Home Phone | Cell Phone

Birth Date | Sex ○ Female ○ Male | Social Security #

Address 1 | Address 2 | City | State | ZIP

Dominant Hand ○ Right ○ Left | Height | Weight | Work Phone

Providers

Who are you here to see? | Primary Care Provider | Referring Provider | Preferred Pharmacy (Name & ZIP)

Emergency Contact

First Name | Last Name | Phone | Relationship

Address | City | State | ZIP

Insurance

Primary Insurance

Carrier | Copay

Certificate or ID # | Group # | Claims ZIP Code

The claims ZIP code can be found on the back of the card.

Carrier	Copay

Certificate or ID #	Group #	Claims ZIP Code

I hereby authorize Dr. Hasbani to release any medical information necessary to the Attorney, No-Fault Insurance Carrier, and Workman's Compensation. I agree to pay my account as services are provided. If for any reason there is a balance owing on my account, I agree to pay promptly upon receipt of the monthly statement. After 3 months outstanding balances will be charged an additional 18% a year. If my account remains unpaid I agree to pay, in addition to the amount due, reasonable attorney fees and court costs if suit is initiated to collect the balance. For missed appointments, you may be responsible for the charge of the visit at the discretion of the doctor. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signature