Laser Spine and Pain Institute
Patient Intake Form

PATIENT INFORMATION

Full Name:_____ Date:_____
First MI Last

Address:_____ City:_____ State:_____ Zip:_____

Age:_____ Birth Date:_____ Male/Female (Please circle one)

Social Security Number:_____-_____-_____ E-mail Address:_____

Home Phone:_____ Work Phone: _____ Cell/Other: _____

Referred By (Please Circle): Friend/Family Referral Internet Search Newspaper Ad Yellow Pages
Walk-by/Drive-by Facebook Google Other _____

I prefer to receive calls at (circle) Home/Work/Cell.
I am (circle) Under Age 18/Single/Married/Divorced/Widowed/Separated

Employer:_____ Occupation:_____

Business Address:_____ City:_____ State:_____ Zip:_____

Spouse's Name:_____ Spouse's Date of Birth:_____

Emergency Contact:_____ Emergency Contact Phone Number:_____

PAYMENT INFOMRATION

Person Responsible for Payment:_____

Social Security Number: _____-_____-_____ Phone:_____ Date of Birth:_____

Consent for Treatment, Assignment & Release *- By signing below, I authorize Laser Spine and Pain Institute to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Laser Spine and Pain Institute, DBA for Yasaman Shaghaghi PLLC, and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment and health care operations.*
By signing below, I give my consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient

Signed:_____ Date:_____