Dolar Koya M.D.S.C. Komal Koya D.O.

PLEASE PRINT CLEARLY

Married _____ Single _____

Patient Name: Last _____ First _____ Middle_____ Divorced _____ Widowed _____

Patient Age _____ Sex _____ Patient Birthdate _____

FOR MINORS

Father's Name _____ Mother's Name _____

Father's Work Phone/Cell _____ Mother's Work Phone/Cell _____

Full Time Student: Yes _____ No _____

Address_____ City _____ Zip _____

Home Phone # _____ Cell Phone # _____

Employer _____ Social Security # _____

Whom May We Thank For Referring You? _____

Name of Your Family Physician _____ PHYSICIAN PHONE # _____

Allergic to Any Medications? _____

INSURANCE INFORMATION

Primary Ins. Co. _____ I.D. # _____

Policy Holder's Name _____ Group # _____

Policy Holder's Date of Birth _____ Policy Holder's Employer _____

Policy Holder's Social Security # _____

Secondary Ins. Co. _____ I.D. # _____

Policy Holder's Name _____ Group # _____

Policy Holder's Date of Birth _____ Policy Holder's Employer _____

Policy Holder's Social Security # _____

PATIENT RELATION TO INSURED (PLS CIRCLE ONE): SELF SPOUSE CHILD STEP-CHILD

I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ALL MY HEALTH INSURANCE CLAIMS. I AUTHORIZE PAYEMENT OF BENEFITS DIRECTLY TO DRS. DOLAR KOYA MDSC OR KOMAL KOYA DO. I HAVE RECEIVED NOTICE OF THE PRIVACY FORM.

SIGNATURE _____ DATE _____