Welcome To The Office of Dr. Birjandi

Patient Information

Date _______________ Home Phone (_____) ______ - _______ E-mail ______________________________________

Last Name _________________________ First Name ________________________ Middle Initial _______ Sex ○ M ⊙ F

Street ____________________________ City _________________________ State ______________ Zip _______________

Social Security # ____________________ Driver's License # ___________________ Age ___ Date of Birth ___/___/___

Marital Status _________________________________ Children? _______________ Ages __________________________

Employer____ Phone (_____) ______ - _______ Ext. _______

Street ____________________________ City _________________________ State ______________ Zip _______________

Occupation _________________________________ May we call you at work? ○ Y ○ N Work Hours _______________

Spouse/Domestic Partner Information (If Applicable)

Home Phone (_____) ______ - _______

Last Name _________________________ First Name ________________________ Middle Initial _______ Sex ○ M ⊙ F

Street ____________________________ City _________________________ State ______________ Zip _______________

Social Security # ____________________ Driver's License # ___________________ Age ___ Date of Birth ___/___/___

Employer____ Phone (_____) ______ - _______ Ext. _______

Street ____________________________ City _________________________ State ______________ Zip _______________

Financially Responsible Party (If different from the patient)

Home Phone (_____) ______ - _______

Last Name _________________________ First Name ________________________ Middle Initial _______ Sex ○ M ○ F

Street ____________________________ City _________________________ State ______________ Zip _______________

Social Security # ____________________ Driver's License # ___________________ Age ___ Date of Birth ___/___/___

Employer____ Phone (_____) ______ - _______ Ext. _______

Street ____________________________ City _________________________ State ______________ Zip _______________

Occupation _________________________________ May we call you at work? ○ Y ○ N Work Hours _______________

Insurance Information (Or provide insurance card on office visit)

Primary Insurer _____________________________ Phone (_____) ______ - _______ Group # _________________

Street (PO Box) ____________________________ City _______________ State _______________ Zip _______________

Insured's name __________________________________ Insured's ID # ____

Secondary Insurer ___________________________Phone (_____) ______ - _______ Group # _________________

Street (PO Box) ____________________________ City _______________ State _______________ Zip _______________

Insured's name __________________________________ Insured's ID # ____

In Case of Emergency

Who should be notified?__________________________ Relationship_____________ Phone (_____) ______ - _______

Who may we thank for referring you? ____

Please read and sign below: I directly assign all medical and surgical benefits to the doctor. I understand that I am financially responsible for all charges whether paid by my insurance provider or not. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that fees for service are payable at the time of service, unless other arrangements are made in advance. It is my responsibility to pay any deductible amount or co-insurance.

It is the policy of this office to bill your insurance for reimbursement. However, we shall allow no more than sixty (60) days for payment. After sixty (60) days you will be billed for any outstanding balance on your account. All outstanding balances are due thirty (30) days from the statement date.

I HEREBY GIVE AUTHORIZATION FOR TREATMENT ______________________________ ___________

Signature Required Date

Nahid Birjandi, D.P.M.

Foot and Ankle Surgery
Podiatric Medicine

Patient Consent for Use and Discloser of Protected Health Information

_____ Initial — With your consent Dr. Nahid Birjandi may use and disclose Protected Information about you to carry out treatment, Payment and Health Care Operations. Please refer to our Notice of Privacy Practices prior to signing this consent. We have the right to revise our Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our Privacy Officer at 27871 Medical Center Rd. Ste. 130. Mission Viejo, CA. 92691.

_____ Initial — With your consent, Dr. Nahid Birjandi and office staff may call your home or office and leave a message in reference to any items that assist the practice in carrying out Treatment, Payment and Health Care Operations such as appointment reminders, insurance items and any call pertaining to your clinical care.

_____ Initial — With your consent, Dr. Nahid Birjandi and office staff may call your home or office and leave a message in reference to any items that assist the practice in carrying out Treatment, Payment and Health Care Operations such as appointment reminders, insurance items and any call pertaining to your clinical care.

_____ Initial — With your consent. Dr. Nahid Birjandi and office staff, may mail to your home or office any items that assist the practice in carrying out Treatment. Payment and Health Care Operations such as appointment reminder cards and patient statements.

_____ Initial — I give my consent to electronically send or fax my records for the purpose of Treatment, Payment or Health Care Operations and understand that I may withdraw this consent at any time in writing. I understand that my medical records may be transmitted electronically or by fax and may be received in error by a third parry. In the event that this should occur I absolve Dr. Nahid Birjandi and office staff of all liability.

_____ Initial — By signing this form, you are consenting to our use and discloser of your Protected Health Information to carry out Treatment, Payment and Health Care Operations. This consent may be revoked in writing except to the extent that we have already made disclosures in reliance upon your prior consent.

If you decline to sign this consent, we may decline to provide treatment for you.

Signature of Patient or Legal Guardian ______________________________ Date ________________

This Authorization Will Remain Standing Until Revoked In Writing.

Patient's Name ____ Date of Birth ________________

Print Name of Patient or Legal Guardian ____________________________ Date ________________

ONLY SIGN BELOW IF YOU ARE DECLINING THIS CONSENT

I, __________________________, decline to the use and disclosure of my Protected Health Information to carry out Treatment, Payment, and Health Care Operations.