Salman Ahmad, M.D., P.A.

2345 50th Street, Ste. 500 Lubbock, TX 79412 (o) 806-701-5797 (f) 806-701-5798

PATIENT'S INFORMATION

Name: Last: _____ First: _____ MI: _____

Address: _____ City: _____ ST: _____ Zip: _____

Home Ph: _____ Work Ph: _____ Cell Ph: _____

Social Security Number: _____ Sex: _____ Age: _____ DOB: _____

Driver's License Number: _____ Patient Notification: Phone/Text _____

Employer's Name: _____

Email Address: _____@ _____

HOW DID YOU HEAR ABOUT US

Please check the following: ☐ Google ☐ FACEBOOK ☐ Friend _____

☐ My Insurance ☐ Physician's Office _____

RESPONSIBLE PARTY INFORMATION

Person Responsible: _____ Social Security #:_____

Address: _____ City _____ ST ____ Zip _____

Home Phone: _____ Cell Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ Phone: _____

Address: _____ City _____ ST _____ Zip _____

Member ID: _____ Group Number: _____

Name of Insured: _____ DOB: _____

Social Security Number _____

Secondary Insurance: _____

PRIMARY CARE PHYSICIAN

Physician Name: _____ Office Phone: _____

Address: _____City _____ ST _____ Zip _____

Are you being referred to our office? Yes or No

If Yes, does your office visit require an Office Referral Authorization? Yes or No

If Yes, please contact your Primary Care Physician to obtain the Referral Authorization for our office, and have that faxed prior to your visit.

Please initial the following:

Initial _____ I understand that my Primary Care Physician must provide an authorization prior to my visit.

Initial _____ I understand that I am responsible to get the Office Referral Authorization, prior to my office visit. If I am unable to obtain the Authorization, your office will reschedule my visit or I will be responsible for the office visit fees.

IN CASE OF AN EMERGENCY, PLEASE NOTIFY:

Name: _____ Relationship to Patient: _____

Address _____ Home Phone _____ Cell Phone _____

Whom may we thank for referring you: _____

I DECLARE THAT THE ABOVE IS TRUE AND CORRECT.

I understand that the Offices of Salman Ahmad will file on visit under the insurance provide. If I withheld information or provided inaccurate information, I will be responsible for any, and all unpaid balances.

_____ _____ _____

Signature Printed Name Date

Thank you for coming, we are always accepting New Patients.