Parvin Shafa M.D.

OC MedDerm, Dermatology

Last Name ______________________________

First Name______________________________

Date of Birth ________________ Age _______

Email __________________________________

How did you find us? _____________________

Driver's License # ________________________

Social security # _________________________

Home address __________________________

City ________________ St _____ Zip _______

Mailing address _________________________

City ________________ St _____ Zip _______

Cell Phone (   ) _______________________

Home Phone (   ) ______________________

Work Phone (   ) ______________________

How may we leave a confidential message for you? **Text** **Voicemail** **Email**

Occupation ____________________________

Patient's employer________________________

Work address __________________________

City ________________ St _____ Zip _______

EMERGENCY CONTACT:

Name & Relation _________________________

Best Phone # (   ) ____________ ? C H W

POLICY HOLDER INFORMATION:

Self Spouse parent Guardian

Full Name _____________________________

DOB of Subscriber _______________________

employer ________________________________

Work phone (   ) ________________________

Address _________________________________

City ________________ St _____ Zip _________

MEDICAL INSURANCE INFORMATION

Insured's Name __________________________

DOB ___________________________________

Name of Insurance comp. __________________

Effective date ____________________________

ID # ___________________________________

Group # ________________________________

Secondary (if any)

Insured's Name __________________________

DOB ___________________________________

Name of Insurance comp. __________________

Effective date ____________________________

ID # ___________________________________

Group # ________________________________

ASSIGNMENT & RELEASE

I hereby authorize the physician to release any information required to process my medical claims.

I also authorize my insurance benefit to be paid directly to Parvin Shafa MD Inc.

I understand and agree that I am financially responsible for non-covered services.

X________________________ Date ________

Patient or guardian signature and date

I hereby authorize treatment of

(Name of minor) ____________________________

By Dr. Parvin Shafa.

X _______________________ Date __________

Signature of guardian