MASROOR A. KHAN, M.D., FACC, FSCAI
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TODAY'S DATE:			**For Office Use Only: PATIENT NO.**	
LAST NAME:		FIRST NAME:		MIDDLE NAME:
BIRTH DATE:		AGE:		SEX:
MARITAL STATUS:	Single ❒	Married ❒	Divorced ❒	Widowed ❒
SOCIAL SECURITY NUMBER:		DRIVER'S LICENSE NO.		State:
HOME ADDRESS:				
CITY:	STATE:	ZIP:	COUNTRY:	
Phone:	Mobile:	E mail:		
EMPLOYER:				
OFFICE ADDRESS:				
CITY	STATE:	ZIPl	COUNTRY:	
Phone	Pager:		E mail	
SPOUSE NAME:				
EMERGENCY CONTACT:			Relationship:	
Work Phone:	Home Ph:		Mobile:	
REFERRAL PHYSICIAN NAME :			Phone:	

INSURANCE INFORMATION

NAME OF INSURED:		SS #	
PRIMARY INSURANCE COMPANY:			
Address:			
Policy Number:		Group Number:	
SECONDARY INSURANCE COMPANY:			
Name of Insured (if different from above)			
Address:			
Policy Number:		Group Number:	
OTHER HEALTH INSURANCES:			

AUTHORIZATION

I hereby authorize Masroor A. Khan MD or associates to examine and treat me. I also authorize to release to my Insurance Company any information acquired in the course of my examination or treatment. I hereby authorize payment directly to Masroor A. Khan MD for surgical and/or medical benefits otherwise payable to me for services rendered. If benefits are payable to me I authorize my Insurance Company or Medicare or Medicaid to furnish to my doctor any information in the adjudication of any claims in regards to services furnished to me. I hereby authorize the use of a photographic reproduction of this authorization in place of the original. I also understand that in case of electronic transmittal of claims to my Insurance Company the notation "Signature on record" will be used. This authorization is valid till I or my legally designated representative revokes it in writing.

YOUR SIGNATURE *TODAY'S DATE*