B.C. Moucharafieh, M.D., F.A.C.S.

400 Newport Center Drive, Suite #704, Newport Beach, CA 92660
(714) 528-5560 FAX: (714) 528-5582

Patient Information Questionnaire

NAME: ______________________________ D.O.B.______________ AGE: ______________

HOME PHONE: (____)______________________ CELLPHONE/ PAGER: (___) ____________________

ADDRESS: ______________________________ CITY: __________ STATE:_______ ZIP:__________

PLEASE CIRCLE: Minor Single Married Widowed Divorced EMAIL ADDRESS________________________

SOCIAL SECURITY NUMBER: ________________ DRIVER'S LICENSE #:______________________

EMPLOYER: ______________________________ WORK PHONE: ______________ EXT. ________

BUSINESS ADDRESS: _________________________ CITY:__________ STATE:_____ ZIP:________

SPOUSE OR PARENTS NAME: __________________ PHONE # ___________________________

EMERGENCY CONTACT: _________________________ PHONE # ________________________

Insurance Information (if applicable)

NAME OF INSURED: ______________________ RELATIONSHIP: ___________________________

BIRTHDATE: ______________ SOCIAL SECURITY # ______________ EMPLOYED SINCE:__________

EMPLOYERS NAME: __________________________ WORK PHONE# _______________________

INSURANCE CARRIER: _________________________ GROUP #___________________________

INSURANCE CO. ADDRESS: ____

CITY: ____ STATE: _______ ZIP:_____________

DEDUCTIBLE AMOUNT: _____________ DEDUCTIBLE MET FOR THIS YEAR? YES NO

WHO MAY WE THANK FOR RREFERRING YOU? : ______________________________

PROCEDURE(S) OF INTEREST: ____

I hereby authorize the release of any medical information necessary to process an insurance claim and further authorize payment of medical or major medical insurance benefits directly to B.C. MOUCHARAFIEH, M.D. I have been informed that my insurance company will be billed as a courtesy only. I agree and understand that I will be fully responsible for 100% of payment for charges not covered or denied by my insurance company. (Pre-arranged contracts will be honored). A deposit may also be required prior to surgery. I hereby grant authority to BASSAM C. MOUCHARAFIEH, M.D. in charge of patient whose name appears above, to administer such treatment and professional services as may be deemed necessary or advisable in the diagnosis and treatment of the patient.

SIGNATURE ________________________________ ***DATE*** ________________