PATIENT DEMOGRAPHIC INFORMATION

PATIENT IDENTIFYING INFORMATION:

FIRST NAME: ______________________________

MIDDLE NAME: ______________________________

LAST NAME: ______________________________

GENDER: __________

DATE OF BIRTH: ______________

SOCIAL SECURITY#: ______________

PATIENT CONTACT INFORMATION

EMAIL: ______________________________

HOME PHONE: ______________________________

MOBIL PHONE: ______________________________

OFFICE PHONE: ______________________________

OFFICE EXTENSION: ______________________________

EMERGENCY CONTACT# ______________________________

PATIENT ADDRESS INFORMATION:

ADDRESS LINE 1: ______________________________

ADDRESS LINE 2: ______________________________

CITY: ______________________________

COUNTY: ______________________________

STATE/ZIP: ______________ / ______________

DR. ASGHAR ANWAR
74 WEST CEDAR STREET
POUGHKEEPSIE, NY 12601
PHONE: 845-454-6174 FAX: 845-454-5371

I, ______________________________ give my permission to Dr. Asghar Anwar to discuss my medical status with the following person (s):

1 ______________________________ relationship ______________________________

2 ______________________________ relationship ______________________________

3 ______________________________ relationship ______________________________

To remove a person (s), it must be submitted to this office in writing.

SIGNED ______________________________ DATE: ________________

WITNESS BY: ______________________________ DATE: ________________

DR. ASGHAR ANWAR
74 WEST CEDAR STREET
POUGHKEEPSIE, NY 12601
PHONE: 845-454-6174 FAX: 845-454-5371

Notice of Privacy Practices Patient Acknowledgement

Patient Name: ______________________________

Date of Birth: ______________________________

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these right's and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practice and to make changes regarding all protected health information president at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: ______________________________

Date: ______________________________

Relationship to patient (if signed by a personal representative of patient):

____

ASGHAR M. ANWAR, M.D.
74 WEST CEDAR ST.
POUGHKEEPSIE, N.Y. 12603

DATE____/____/________
mm dd yyyy

SOCIAL SECURITY______-_____-_____

PATIENT NAME:____________________ ____________________ ____________
Last First Middle Initial

ADDRESS:____ ____________
Street Apt.#

____ ________ ________
City State Zip

TELEPHONE:________________________ WORK:________________________

DATE OF BIRTH:____/____/______
mm dd yyyy

SEX: ( ) MALE ( ) FEMALE

MARITIAL STATUS: Single___ Married___ Divorced___ Separated___ Widow/er___

OCCUPATION:________________________ EMPLOYER:________________________

ADDRESS:____

CITY:________________________ STATE:______ ZIP:__________

SPOUSE'S NAME:________________________ SPOUSE'S OCCUPATION:____________________

NEAREST RELATIVE NOT LIVING WITH ME TO CONTACT IN CASE OF AN EMERGENCY:
NAME________________________ TELEPHONE________________________

PRIMARY INSURANCE COMPANY:____

IDENTITY NO:______________ GROUP NO:______________ CO PAY $____________

POLICY OWNER ( ) MYSELF ( ) MY SPOUSE

SECONDARY INSURANCE COMPANY:____

IDENTITY NO:________________ GROUP NO:________________ CO PAY $________

DATE OF LAST EXAM:____/____/______ REFERED HERE BY:____________________

I authorize the release of any medical information necessary to process my insurance claim:
PATIENT'S SIGNATURE:____

I hereby assign payment of benefits from my insurance to Dr. Anwar Asghar MD not exceeding the reasonable and customary charges for these services.

INSURED'S SIGNATURE:____