

ATA AHMAD, M.D., F.A.C.S.

11740 FM 1960 W
HOUSTON, TX. 77065
Phone: (281) 970-8484 Fax: (281) 970-8485

PATIENT INFORMATION

Please **PRINT** and **FILL** in **ALL** blanks

Patient Name: _____
Last First Middle

Address: _____
City State Zip

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Date of Birth: ____/____/____ Age: _____ Social Security#: ____-____-____

TDL# _____ Single ___ Married ___ Widow ___ Divorced MALE / FEMALE

Employer: _____
Address City State Zip

Medication Allergies: _____

INSURANCE INFORMATION or RESPONSIBLE PARTY

Insurance Company: _____ Insurance Phone#: (____) _____

Policy / SS / ID#: _____ Group #: _____

Insurance Address: _____

Name of Policy Holder: _____ DOB: ____/____/____ Social Security#: ____-____-____
City State Zip

SECONDARY / SUPPLEMENTAL INSURANCE INFORMATION

Insurance Company: _____ Insurance Phone#: (____) _____

Policy / SS / ID# _____ Group # _____

Insurance Address: _____

City State Zip

Name of Policy Holder: _____ DOB: ____/____/____ Social Security# ____-____-____

In case of an emergency notify _____
Phone no. Relationship

Who May We Thank For Referring You To Our Office?

Phone No. Fax No.

IMPORTANT: PLEASE SIGN AUTHORIZATION BELOW FOR OUR RECORDS

I AUTHORIZE ATA AHMAD M.D., F.A.C.S., AND STAFF THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO PERMIT PAYMENT TO BE MADE DIRECTLY TO ATA AHMAD, M.D., F.A.C.S. FOR SERVICES RENDERED. I ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY POLICY AND PRACTICES FOR ATA AHMAD, M.D., F.A.C.S.. I UNDERSTAND AND ACCEPT THE ABOVE STATED POLICIES AND AGREE TO ADHERE TO SUCH BY SIGNING MY NAME BELOW. A PHOTO STATIC COPY OF MY SIGNATURE WILL SERVE AS AN ORIGINAL.

SIGNED: _____ DATE: _____