Rose T. Codini, MD/Poneh Rahimi, MD
Gastroenterology & Hepatology

PATIENT INFORMATION SHEET

FIRST NAME:____________________________MIDDLE INT:______LAST NAME:__________________________________

ADDRESS:____

CITY:____STATE:______________ZIP:__________________________

HOME #_________________________WK#______________________________CELL#______________________________

BIRTHDATE:_____________________SS#_____________________________E-MAIL________________________________

AGE:____________ SEX: F M MARITAL STATUS: S M W D OTHER

REFERRED BY:__________________________________FAMILY DOCTOR:______________________________________

EMPLOYER:_____________________________________OCCUPATION:____

ADDRESS:____

CITY:____STATE:____________ZIP:______________________________

SPOUSE/NEAREST RELATIVE:___________________________________PHONE:______________________________

SPOUSES EMPLOYER:_____________________________BIRTHDATE:______________SS#_________________________

EMERGENCY CONTACT:______________________________________RELATION/PHONE:________________________

PRIMARY INSURANCE

COMPANY:________________________________

ID#_______________________________________

GROUP#___________________________________

INSURED:_________________________________

CO-PAY:__________________________________

SECONDARY INSURANCE

COMPANY:_______________________________________

ID#____

GROUP#____

INSURED:_______________________________________

CO-PAY:____

I guarantee payment to Rose T. Codini, M.D. I authorize my insurance company(ies) to pay any and all charges rendered on my behalf directly to Rose T. Codini, M.D. I will be responsible for and will guarantee payment on any and all charges, which may not be paid or covered by my insurance company(ies). I understand payment in full may be required at the time of service (for your convenience we accept money orders, checks, cash, Visa, and MasterCard). I certify that the information given, including insurance coverage is complete and correct. I have read and understand Dr. Codini's cancellation fee policy. I understand if my account is submitted for collection I will be charged a 30% fee of the balance that is transferred to the collection agency. I understand the returned check fee is $25.00.

SIGNATURE____DATE_____________________________