THOMAS N. KIAS, M.D., P.C.

(Circle one) Dr. Kias Dr. Jarrard Dr. Johnson

Patient Name_____

Address_____

City_____ ST _____ Zip_____

Home Phone_____ Cell # _____ Email _____

Date of Birth _____ SS# _____ [ ] Male [ ] Female

Employer_____

[ ] Asian [ ] Black [ ] Hispanic [ ] White [ ] Other [ ] Divorced [ ] Married [ ] Single [ ] Widow

Preferred Drug Store_____ Phone_____

Referred by_____

Request for Alternative Communications Voice Mail [ ] Yes [ ] No Text [ ] Yes [ ] No

My messages and/or health information may be given to the following representatives:

Name	Phone	Relationship
_____	_____	_____
_____	_____	_____

Emergency Contact: List persons that we can contact in case of an emergency.

Name	Phone	Relationship	Release Information
_____	_____	_____	[ ] Yes [ ] No
_____	_____	_____	[ ] Yes [ ] No

Insurance: MEDICARE HMO PPO TRADITIONAL NONE

Primary Insurance Company _____

Secondary Insurance Company _____

Assignment of Benefits: I hereby assign all medical and/or surgical benefits in which I am entitled including major medical, Medicare, private insurance and any other plans to Thomas N. Kias, M.D., P.C. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. If I choose not to sign, I will be responsible for all charges.

_____ _____

Name Date