

**Lamia Gabal-Shehab, M.D.
Jeffrey Kaufman, M.D., Inc.**

Date: _____


PATIENT INFORMATION	Name: _____		Age: _____	
	First	Middle	Maiden	Last
	Marital Status: Married <input type="checkbox"/>	Single <input type="checkbox"/>	Date of Birth: _____ / ____ / ____	
	Separated <input type="checkbox"/>	Divorced <input type="checkbox"/>	Social Security Number: _____ - ____ - ____	
	Home Address: _____			
	Street	City	State	Zip
	Home Phone: (____) _____		Business Phone (____) _____	
	Employed By: _____		Occupation: _____	
	Business Address: _____			
	Street	City	State	Zip
Spouse's Name: _____		Spouse's S.S. No: _____ - ____ - ____		
Spouse Employed By: _____		Spouse's Occupation: _____		
Spouse's Date of Birth: _____ / ____ / ____		Spouse's Business Phone: (____) _____		

If Patient is Minor, Person Legally Responsible for payment or Parent/Guardian:

Name: _____		
First	Middle	Last
Address: _____		Employed By: _____
Business Address: _____		Business Phone: (____) _____


Authorization to Pay Benefits to Physician:

I hereby authorize payment directly to the undersigned Physician of Surgical and/or Medical Benefits, if any, otherwise payable to me for his services described here. I understand that I am financially responsible for all charges not covered by this authorization.

 _____
Signed (Insured Person) _____
Date

Authorization to Release Information:

I hereby authorize the undersigned Physician to release any medical information necessary to my Insurance Company to process any claims.

 _____
Signed (Insured Person) _____
Date

Who referred you to this office? _____