AIJAZ A. KHALID, M.D. PATIENT HISTORY/DEMOGRAPHICS FORM

PATIENT'S FULL NAME _____ DATE OF BIRTH_____

STREET ADDRESS _____ HOME PHONE_____

CITY_____ STATE_____ ZIP CODE_____

PATIENT'S SEX: M____ F_____ SS# _____/_____/_____

LEGAL GUARDIAN/CUSTODY NAME_____RELATIONSHIP_____

MOTHER'S NAME_____ EMPLOYER _____

HOME PHONE _____ WORK PHONE _____

FATHER'S NAME _____ EMPLOYER _____

HOME PHONE _____ WORK PHONE _____

STREET ADDRESS (MOTHER/FATHER) _____

MAILING ADDRESS _____

PHARMACY _____ PHONE NUMBER_____

REFERRING PHYSICIAN _____ ADDRESS_____ PHONE #_____

IN CASE OF EMERGENCY, CONTACT _____ PHONE # _____

PERSON RESPONSIBLE FOR BILL _____ADDRESS_____

INSURANCE COMPANY NAME_____ADDRESS_____

SUBSCRIBER NAME_____SUB. SS#_____

SUB'S EMPLOYER_____GROUP#_____POLICY#_____

CHAMPUS ONLY: SPONSOR'S NAME_____ID#_____

ACTIVE_____ RETIRED_____ BRANCH OF SERVICE_____

MEDICAID OR MEDICARE ONLY: MEDICAID #_____MEDICARE #_____

HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING? CHECK ANY THAT APPLY

- ☐ FREQUENT HEADACHES
- ☐ DIFFICULTY BREATHING
- ☐ VISION PROBLEMS
- ☐ FAINTING
- ☐ DIZZINESS
- ☐ CONVULSIONS/SEIZURES
- ☐ EXCESSIVE FATIGUE
- ☐ ASTHMA/HAY FEVER
- ☐ FEVER
- ☐ MEMORY IMPAIRMENT
- ☐ ALLERGIES
- ☐ UNUSUAL WEIGHT GAIN OR LOSS
- ☐ ABNORMAL BLEEDING
- ☐ NIGHT SWEATS
- ☐ NERVOUS BREAKDOWN
- ☐ PERSISTENT COUGH
- ☐ OPERATIONS_____ _____
- ☐ OTHER INJURIES_____
- ☐ SERIOUS ILLNESS_____
- ☐ MEDICATIONS CURRENTLY TAKING (LIST)_____ _____

FAMILY HISTORY OF NEUROLOGICAL DISEASE?
___SEIZURES ___MIGRAINES
___CANCER ___LEARNING DISABILITY

I HEREBY AUTHORIZE DR. AIJAZ A. KHALID TO FURNISH INFORMATION TO INSURANCE CARRIER ABOUT MY ILLNESS AND TREATMENT. I HEREBY ASSIGN TO THIS PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS, IF ANY, REGARDLESS OF MY INSURANCE BENEFITS. I UNDERSTAND THAT I AM RESPONSIBLE FOR THE FEES FOR ANY SERVICES RENDERED.

SIGNATURE_____DATE_____