Shabbir Jamali, MD PA
Board Certified In Gastroenterology
281-357-1977

Patient Demographics

Full Name:__________________ D.O.B:________ Age:__________ Sex: ☐ M ☐ F

Marital Status: ☐ Single, ☐ Married, ☐ Widowed, ☐ Separated, ☐ Divorced, ☐ Minor, if so name of the Parent__________________

Home Address: ____________________ City: ______________ State: _________ Zip: __________

Home Phone: (__________)____________________ Work: (_______)____________________ S.S #: ____________________

Cell Phone: (______)____________________Primary Care Physician: ____________________

Work Address: ____________________ City: ______________ State: _________Zip: __________

Employer:____________________ Supervisor:____________________ Occupation: __________________
Patient's (Parent if patient is a minor)

Email Address: ____________________

Emergency Contact:____________________ Relationship:________________ Phone #:____________________

Primary Insurance:

Name of Policy Holder:____________________ Relationship: ☐ Self, ☐ Spouse, ☐ Parent, S.S____________________

Date of Birth of Policy Holder:____________________

Employer: ____________________ Work Address: ____________________

Name of Insurance Co.: 1.____________________ 2. ____________________

Policy No./ Group No.: 1. ____________________ 2. ____________________

Annual Deductible? ☐ Yes ☐ No, How Much?___________ What portions have you met? ___________ Copay? _______________

Would you like us to file the insurance for their portion of the charges? ☐ Yes ☐ No

☐ Self Pay, ☐ Medicare, ☐ Medicaid, ☐ Work Comp, ☐ LOP, Secondary Insurance? ☐ Yes ☐ No

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Assignment and Release:

I, the undersigned certify that I (or my dependent) have insurance coverage with the above mentioned insurance company and assign directly to **Shabbir Jamali, MD** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits, I authorize the use of this signature on all insurance submissions.

____________________ ____________________ ____________________
Responsible Party Signature Relationship Date