KAVEH BAGHERI M.D., F.A.C.P., F.C.C.P.

Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB:**
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Address:	**City:**		**Zip:**
Home phone:	**Mobile#**		**Email:**
PCP / Referring MD:			
Primary Insurance:		**Policy #**	
Secondary Insurance:		**Policy #**	
Main Problem (reason for the visit):			

Assignment of Insurance Benefits:

I hereby authorize and request my insurance company to pay directly to Dr. Kaveh Bagheri the amount (s) due on my claim for services rendered to me or my dependent. I further agree that should the amount be insufficient to cover the entire medical and surgical expense, I will be responsible for payment of the difference; and if the nature of the disability be such that it is not covered by the policy, I will be responsible to the doctor for payment of the entire bill.

Signature: _____ Date: _____