PARGOL SAMANI, M.D., INC.
3927 Waring Rd, Suite C, Oceanside, CA 92056

PATIENT REGISTRATION FORM

Patient Information:

First Name:	Last Name:
Sex: ☐Male ☐Female	Date of Birth:
SSN:	Occupation:
Address: City:	State: Zip Code:
Mobile Phone: Home Phone:	Email: Work Phone:
Primary Care Doctor:	Referred By:
Pharmacy Name/Address:	Lab Name/Address:
Emergency Contact Name:	Emergency Contact Phone:
Guardian First Name:	Guardian Last Name:

Insurance Information:

Primary Insurance:	Secondary Insurance:
Insured's Name (if different from patient):	Insured's SSN (if different from patient):
Insured's Address (if different from patient):	Insured's Phone Number (if different from patient):

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Pargol Samani M.D. Inc. I understand that I am financially responsible for any balance. I also authorize Pargol Samani M.D. Inc. or insurance company to release any information required to process my claims. I also acknowledge receipt of the Notice of privacy practice.

Patient/Guardian signature

Date