WESTWIND MEDICAL ASSOCIATES
HEALTH & WELLNESS CENTER

Patient Registration Form

Dr. Mina Haidarian M.D.
6604 Westwind Drive
El Paso, TX 79912
Phone: 915-845-4600
Fax: 915-845-4602

Patient's Personal Information

Patient Last Name: First Name: Middle Initial:

Social Security #: Date Of Birth: *(month/day/year)*

Home Phone: Cell Phone:

Address: Apt. #: City: State: Zip:

Patient's / Responsible Party Information

Patient Last Name: First Name: Middle Initial:

Social Security #: Date Of Birth: *(month/day/year)*

Home Phone: Cell Phone:

Address: Apt. #: City: State: Zip:

Patient's Insurance Information

PRIMARY Insurance Provider Name:

Address: City: State: Zip:

Name of Insured: D.O.B. *(month/day/year):*

Relationship to Self: Policy #: Group #: Copay $:

SECONDARY Insurance Provider Name:

Address: City: State: Zip:

Name of Insured: D.O.B. *(month/day/year):*

Relationship to Self: Policy #: Group #: Copay $:

Patient's Referral Information

Name:

Address: City: State: Zip:

Phone: Fax:

Patient's Pharmacy Information

Name:

Address: City: State: Zip:

Phone: Fax:

Patient's Emergency Contact

Name: Relationship to Self:

Address: City: State: Zip:

Home Phone: Cell Phone:

Assignment of Benefits - Financial Agreement

I herby give lifetime authorization for payment of insurance benefits to be made directly to Westwind Medical Associates, P.A. , and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

I further agree that a photocopy of this agreement shall be as valid as the original.

Patient/Parent/Guardian Signature _____ Date: