Date _____ _____
fecha _____ _____

FARIBORZ SHAMS, D.O. **SELMA PRECHEL, D.O.**
515 S. Beach Blvd., Suite F, Anaheim, CA. 92804
(714) 995-7503 FAX (714) 995-7743

HAVE YOU BEEN TO OUR OFFICE BEFORE FOR ANY REASON? **() YES () NO**
A estado en nuestra oficina por cualquier razon anteriormente?

*PATIENT LAST NAME pt apellido	*FIRST nombre	*M. I. 2o. nombre	*AGE edad	*SEX sexo	*DATE OF BIRTH nacimiento	*OCCUPATION ocupacion

* ADDRESS direccion	*CITY ciudad	*STATE estado	*ZIP codigo	*HOME PHONE # tel. casa

*SOCIAL SECURITY # seguro social	*DRIVERS LICENCE # (COPY) licencia de manejo	*MARTIAL STATUS edo. civil

*EMPLOYED BY empleador	*ADDRESS direccion	* CITY & STATE cd./ edo	*ZIP codigo	*WORK PHONE # trabajo tel.

*SPOUSE NAME esposo (a) nom.	EMPLOYED BY empleador	ADDRESS direccion	CITY & STATE cd./edo.	ZIP codigo	PHONE NUMBER telefono

*EMERGENCY CONTACT (NOT SPOUSE) emergencia (no esposo-a)	*RELATIONSHIP relacion	*PHONE NUMBER telefono

INSURANCE INFORMATION

*PRIMARY INSURANCE 1ra. aseguranza	*INSURANCE ADDRESS direccion	*CITY ciudad	*STATE edo.	*ZIP codigo

*SUBSCIBER NAME subscriptor	*I.D. NUMBER ID numero	*SEX sexo	*DATE OF BIRTH nacimiento	*INSURANCE PHONE # aseguranza telefon

*SECONDARY INSURANCE 2a. aseguranza	*INSURANCE ADDRESS aseguranza direccion	*CITY ciudad	*STATE estado	*ZIP codigo

*SUBSCIBER NAME subscriptor	*I.D. NUMBER ID numero	*SEX sexo	*DATE OF BIRTH nacimiento	*INSURANCE PHONE # aseguranza tel.

DO YOU HAVE A CO-PAY? _____ AMOUNT _____
tiene co-pago? cantidad

TREATMENT/PAYMENT AUTHORIZATION to Anaheim Family Medical Center :
Dr. Fariborz Shams, D.O. / Dr. Selma Prechel, D.O.

Permission is granted for treatment along with authorization to release information as necessary by the above named physician. I further authorize payment to be made directly to the above named medical group for any medical, surgical or diagnostic treatment that I have not paid in full. **I understand that I am financially responsible for all charges and that my insurance company is billed for some procedures, as a courtesy to me and does not guarantee payment.** I agree that in the event of default in payment, of any amount due, and if this account is placed in the hands of an agency or attorney for collection or legal action, to pay an additional charge equal to the cost of collection, including agency and attorney fees and court costs incurred and permitted by the laws governing these transactions.

***SIGNATURE** firma ***DATE** fecha