Aslam Loya, M.D., F.A.C.P. **Munir Loya, M.D.**

Coastal Medical Group
11920 Astoria Blvd Ste 110
281-464-8484

PATIENT INFORMATION

LAST NAME:_________________________ FIRST NAME_________________________ MID IN. ____ SEX: M___ F___

ADDRESS _________________________________ CITY _____________________ ST:__________ ZIP: ___________
(NO PO BOX PLEASE)

HOME PH#: (   )_________-__________CELL PH #: (   )__________-___________ MARITAL STATUS ______

SOC. SEC.# _______________________ BIRTHDATE: _______________ AGE: _________ DL# ___________________

EMAIL ADDRESS: _________________________________ EMPLOYED BY: ____________________________

EMPLOYER PHONE #: (   )___________-_____________ CONTACT PERSON: ________________________

EMPLOYER ADDRESS: ____________________________ CITY __________________ ST _________ ZIP__________

PRIMARY MEDICAL INS. CO: ____________________________ POLICY # __________________________

ADDRESS: __________________________________ GROUP # _____________________________

SECONDARY INSURANCE____POLICY#___________________________

ADRESS:____GROUP#___________________________

SPOUSE__________GUARDIAN________NAME________________________________SS#______________________

BIRTHDATE:________________PHONE#:_____________________________WORK#:___________________________

REFERRED BY:____

NEXT OF KIN:_____________________________PHONE#:_____________________WORK#:_____________________
IN CASE OF EMERGENCY NOTIFY: (OTHER THAN HOME AND BUSINESS)

1.____PHONE:____________________WORK:___________________

2.____PHONE:____________________WORK:___________________

AUTHORIZATION FOR MEDICAL CARE: I HEREBY REQUEST AND AUTHORIZE THE EXAMINATION AND TREATMENT OF THE ABOVE NAMED PATIENT. **RELEASE OF INFORMATION AND ASSIGNMENT OF INSURANCE COMPANY BENEFITS**: I HEREBY REQUEST AND AUTHORIZE THE RELEASE OF ANY INFORMATION AND FOR THE PAYMENT OF INSURANCE COMPANY BENEFITS TO COASTAL MEDICAL GROUP. IF THE INSURANCE COMPANY DENIES RESPONSIBILITY, I ACKNOWLEDGE AND UNDERSTAND THAT I AM RESPONSIBLE FOR ALL SERVICES RENDERED TO ME. I CERTIFY THE ABOVE INFORMATION TO BE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE:____DATE:___________________________

INTERPRETER'S SIGNATURE:_______________________________________DATE:___________________________