MALIK EYE INSTITUTE
Masud Malik, M.D.

REGISTRATION
(please print)

DATE ______________________________

PATIENT NAME ______________________________

STREET ADDRESS ______________________________

CITY, STATE & ZIP CODE ______________________________ ______________

BIRTHDATE ______________________________ SOCIAL SECURITY NUMBER ______________________________

TELEPHONE (HOME) ______________________________ (CELL) ______________________________

☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED

PATIENT EMPLOYED BY ______________________________
STREET ADDRESS ______________________________
CITY ______________________________

OCCUPATION ______________________________ TELEPHONE (WORK) ______________________________

DO YOU HAVE INSURANCE? ☐ YES ☐ NO IF YES, PLEASE ANSWER THE FOLLOWING:
NAME OF PRIMARY INSURER ______________________________

NAME OF SECONDARY INSURER ______________________________

ARE YOU THE PRIMARY INSURED? ☐ YES ☐ NO IF NO, PLEASE ANSWER THE FOLLOWING:
PRIMARY INSURED'S NAME ______________________________ RELATIONSHIP ______________

BIRTHDATE ______________________________ SOCIAL SECURITY NUMBER ______________________________

EMPLOYED BY ______________________________
STREET ADDRESS ______________________________
CITY ______________________________

OCCUPATION ______________________________ TELEPHONE (WORK) ______________________________

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? ______________________________ RELATIONSHIP ______________
TELEPHONE ______________________________

WERE YOU REFERRED BY ANOTHER PHYSICIAN? ☐ YES ☐ NO
IF YES, WHO? ______________________________

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage and assign directly to Dr. Masud Malik and Malik Eye Institute all medical benefits for services rendered. I understand that I am financially responsible for all charges whether paid or unpaid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits and also to facilitate further medical care with other physicians. I authorize the use of this signature on all of my insurance submissions.

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SIGNATURE