

PATIENT INFORMATION SHEET
ROBERT G SAIEG MD

TODAYS DATE _____

YOUR PRIMARY CARE PHYSICIAN _____

ALLERGIES _____

NAME _____ DOB _____ SS # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

WINTER/SUMMER ADDRESS _____

EMAIL ADDRESS _____

MARITAL STATUS: S W D M PHONE: H # _____ CELL # _____

YOUR EMPLOYER _____ OCCUPATION _____ WORK # _____

SPOUSE'S NAME _____ SS# _____

SPOUSE'S EMPLOYER _____ WORK # _____

EMERGENCY CONTACT: NAME _____ PHONE # _____

I CONSENT TO TREATMENT NECESSARY FOR THE CARE OF THE ABOVE NAMED PATIENT. I AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS TO THE REFERRING, AND FAMILY PHYSICIANS, AND TO MY INSURANCE COMPANY IF APPLICABLE. I ALLOW FAX TRANSMITTAL OF MY MEDICAL RECORDS, IF NECESSARY. I ACKNOWLEDGE FULL FINANCIAL RESPONSIBILITY RENDERED BY DR. ROBERT SAIEG. I UNDERSTAND THAT PAYMENT OF CHARGES INCURRED IS DUE AT THE TIME OF SERVICE, UNLESS OTHER DEFINITE FINANCIAL ARRANGEMENTS HAVE BEEN MADE. I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT. THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL.

DATE _____ **SIGNATURE** _____

MICHIGAN LAW REQUIRES PHYSICIANS TO ADVISE PATIENTS ABOUT THEIR RIGHT TO CREATE AN ADVANCE DIRECTIVE.

YES **NO** I WOULD LIKE A COPY OF THE ADVANCE DIRECTIVE. **INITIALS** _____

PRIVACY POLICY
I WOULD LIKE TO REQUEST THAT THE FOLLOWING DESIGNATED PERSON BE GIVEN ACCESS TO MY RECORDS AND/OR MEDICAL CONDITION, ALLOWING THE PHYSICIAN AND STAFF TO DISCUSS PERSONAL, FINANCIAL, MEDICAL AND/OR CHANGES IN MEDICATION OR TREATMENT IF I AM UNABLE TO BE REACHED.

NAME AND RELATIONSHIP _____

PATIENT SIGNATURE _____ **DATE** _____

MAY WE LEAVE A MESSAGE REGARDING BILLING OR RESULTS? _____