OBGYN of Jacksonville

TopLine MD Alliance

Patient Information

Name: _____ Age: _____ Date of Birth: _____

SS# _____ Married ( ) Single ( )

Race ( ) Blk ( ) Cauc ( ) Hisp ( ) Asian ( ) Other

S.O/G.I.- Heterosexual ( ) Homosexual ( ) Declined to specify ( ) / Male ( ) Female ( ) Other ( ) Declined to specify ( )

Primary Phone Number: _____ Secondary Phone Number: _____

Address: _____ City: _____ Zipcode: _____

E-mail Address: _____ for patient portal purposes only

Employer Name: _____

Emergency Contact Person: _____ Phone Number: _____

Relationship of Emergency Contact to you _____

Primary Care Doctor Information

Primary Care Doctor Name: _____ Phone Number: _____

Insurance Information

Insurance Number 1

Name of Insurance: _____ Policy Number: _____

Who is the subscriber on the policy? _____ Relationship to you? _____

Subscribers DOB: _____

Insurance Number 2

Name of Insurance: _____ Policy Number: _____

Pharmacy Name and address: _____

I consent to be examined and treated by G. Q. Khan, MD and his staff. I also, hereby, authorize payment of benefits directly to G. Q. Khan, MD otherwise payable to me under the terms of my policy. I understand and agree that I am responsible for any unpaid balances not paid by my insurance carrier. I further authorize G. Q. Khan, MD to release any medical information necessary in processing my medical claims. I authorize my insurance carrier to accept a photocopy of this agreement in lieu of the original.

Date: _____ Patient Signature: _____

Only if patient is a minor: Parent printed name_____

Relationship to patient: _____Parent Signature: _____