WeCare Family Medicine
Hamid Ehsani, M.D.
10632 Little Patuxent Parkway Suite #219
Columbia, MD 21044

Patient Registration

First Name: _____ **Last Name:** _____

Social Security Number: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State/Zip Code:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Marital Status: _____ **Gender:** _____

Emergency Contact

Name: _____ **Relationship:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Insurance Information

Primary Insurance: _____ **ID#:** _____

Co-pay: **Yes** **No** **Amount:** _____

Policy Holder Name _____ **DOB:** _____ **Gender:** _____

I hereby authorize Dr. Ehsani, M.D., P.A to apply for benefits on my behalf for covered services rendered by his office. I request that payments from my insurance be made directly to the doctor. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY UNPAID BALANCE BY THE INSUARANCE COMPANY WITHIN SIXTY(60) DAYS OF THE DATE OF THE SERVICE. I certify that the information I have reported with regards to my insurance is accurate. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at anytime by written request.

Signature: _____ **Date:** _____