Ahmed & Ahmed Physicians, P.C.

8207 Main Street, Suite 7 & 8
Williamsville, NY 14221
(716) 626-4200 (phone) & (716) 626-4201 (fax)

REGISTRATION FORM

Patient Information **Date_____**

Name:_____ I prefer to be called:_____

Address:_____ City:_____ State:____ Zip_____

Phone: (___)_____ Work: (___)_____ Cell Phone: (_ _)_____

The best time to contact me is:_____☐A.M. ☐P.M. on my ☐Home phone ☐Work phone ☐Cell phone

Date of Birth:_____ Social Security Number:_____

Check Appropriate Box: ☐Minor ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

If Student, Name of School:_____ City/State_____ ☐FT ☐PT

Spouse or Parent's Name:_____ Employer:_____ Work Phone (____)_____

Primary Physician:_____ Referring Physician:_____

Person to contact in case of emergency:_____ Phone (____)_____

Email Address:_____

Pharmacy Phone Number: (___)_____ Pharmacy Name & Address_____

Please Read and Sign this Form:

I hereby authorize my insurance benefits to be paid directly to Ahmed & Ahmed Physicians, P.C. I understand and am responsible for all charges including my added costs incurred due any effort to collect for services rendered. I realize I am responsible to pay for non-covered services and I hereby authorized the release of pertinent medical information to insurance carriers.

Signature of Responsible Party:_____ Date:_____