

B.C. Moucharafieh, M.D., F.A.C.S.  
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**Patient Information Questionnaire**

NAME: \_\_\_\_\_ D.O.B. \_\_\_\_\_ AGE: \_\_\_\_\_  
HOME PHONE: ( \_\_\_\_ ) \_\_\_\_\_ CELLPHONE/ PAGER: ( \_\_\_\_ ) \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
PLEASE CIRCLE: Minor Single Married Widowed Divorced EMAIL ADDRESS \_\_\_\_\_  
SOCIAL SECURITY NUMBER: \_\_\_\_\_ DRIVER'S LICENSE #: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ EXT. \_\_\_\_\_  
BUSINESS ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
SPOUSE OR PARENTS NAME: \_\_\_\_\_ PHONE # \_\_\_\_\_  
EMERGENCY CONTACT: \_\_\_\_\_ PHONE # \_\_\_\_\_

**Insurance Information (if applicable)**

NAME OF INSURED: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
BIRTHDATE: \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ EMPLOYED SINCE: \_\_\_\_\_  
EMPLOYERS NAME: \_\_\_\_\_ WORK PHONE# \_\_\_\_\_  
INSURANCE CARRIER: \_\_\_\_\_ GROUP # \_\_\_\_\_  
INSURANCE CO. ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
DEDUCTIBLE AMOUNT: \_\_\_\_\_ DEDUCTIBLE MET FOR THIS YEAR? YES NO

**WHO MAY WE THANK FOR RREFERRING YOU? :** \_\_\_\_\_

**PROCEDURE(S) OF INTEREST:** \_\_\_\_\_

*I hereby authorize the release of any medical information necessary to process an insurance claim and further authorize payment of medical or major medical insurance benefits directly to B.C. MOUCHARAFIEH, M.D. I have been informed that my insurance company will be billed as a courtesy only. I agree and understand that I will be fully responsible for 100% of payment for charges not covered or denied by my insurance company. (Pre-arranged contracts will be honored). A deposit may also be required prior to surgery. I hereby grant authority to BASSAM C. MOUCHARAFIEH, M.D. in charge of patient whose name appears above, to administer such treatment and professional services as may be deemed necessary or advisable in the diagnosis and treatment of the patient.*

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_