

# RAYSHAD OSHTORY, M.D.

2299 Post Street, Suite 107 • San Francisco, CA 94115  
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## Confidential Intake Form—New Patient (Private Insurance/Self-pay) (To safeguard your information, please do not e-mail this form to us)

TODAY'S DATE	TYPE OF APPOINTMENT <input type="checkbox"/> New-patient consultation <input type="checkbox"/> Second opinion	LANGUAGE SPOKEN
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### Contact Information

LAST NAME		FIRST NAME (ANY INITIALS; NAME YOU GO BY)		MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>
HOME ADDRESS			HOME TELEPHONE	CELL	
.....			WORK TELEPHONE	FAX	
EMPLOYED <input type="checkbox"/>	OCCUPATION	UNEMPLOYED <input type="checkbox"/>	RETIRED <input type="checkbox"/>	E-MAIL	
IF EMPLOYED, EMPLOYER NAME AND ADDRESS			<input type="checkbox"/> EMPLOYED PART-TIME	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED	
.....			<input type="checkbox"/> EMPLOYED FULL-TIME	<input type="checkbox"/> PARTNERED <input type="checkbox"/> DIVORCED	
.....			<input type="checkbox"/> STUDENT	SPOUSE/PARTNER NAME	DOB
.....			<input type="checkbox"/> Part-time <input type="checkbox"/> Full-time	.....	
DATE OF INJURY	TESTS <input type="checkbox"/> X-rays <input type="checkbox"/> MRI <input type="checkbox"/> Other	DATE OF BIRTH	AGE	SOCIAL SECURITY NUMBER	
DIAGNOSIS/DESCRIPTION OF INJURED BODY PART(S)/SUMMARY OF DETAILS/SYMPTOMS					

### Primary Insurance

INSURANCE CARRIER (COMPANY NAME)		TYPE <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Self-pay	GROUP NUMBER
ADDRESS OF INSURANCE CARRIER		SUBSCRIBER'S ID NUMBER	PLAN CODE
.....		SUBSCRIBER'S NAME	
BENEFITS/CUSTOMER SERVICE TELEPHONE		SUBSCRIBER'S ADDRESS	
.....		.....	
AMOUNT OF DEDUCTIBLE \$	DEDUCTIBLE HAS BEEN MET <input type="checkbox"/> Yes <input type="checkbox"/> No	SUBSCRIBER'S TELEPHONE	
AMOUNT OF COPAYMENT \$		RELATIONSHIP TO SUBSCRIBER	

### Secondary Insurance

INSURANCE CARRIER (COMPANY NAME)		TYPE <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Self-pay	GROUP NUMBER
ADDRESS OF INSURANCE CARRIER		SUBSCRIBER'S ID NUMBER	PLAN CODE
.....		SUBSCRIBER'S NAME	
BENEFITS/CUSTOMER SERVICE TELEPHONE		SUBSCRIBER'S ADDRESS	
.....		.....	
AMOUNT OF DEDUCTIBLE \$	DEDUCTIBLE HAS BEEN MET <input type="checkbox"/> Yes <input type="checkbox"/> No	SUBSCRIBER'S TELEPHONE	
AMOUNT OF COPAYMENT \$		RELATIONSHIP TO SUBSCRIBER	

### Referral Information

REFERRED BY	RELATIONSHIP TO PATIENT	TELEPHONE
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### In Case of Emergency

CONTACT PERSON	RELATIONSHIP TO PATIENT	TELEPHONE
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I hereby assign medical and/or surgical payments—including major medical benefits to which I am entitled, private insurance, and proceeds from any other health plan—to Rayshad Oshtory, M.D., for services he provides. This assignment shall remain in effect until I submit a written revocation to him. I understand that I am financially responsible for all charges for the provided services, whether or not they are paid for by such insurance. I hereby authorize assignee to release any of the above information to secure payment. A copy of this assignment shall be as valid as the original.

Date: \_\_\_\_\_

Patient Acknowledgment: \_\_\_\_\_