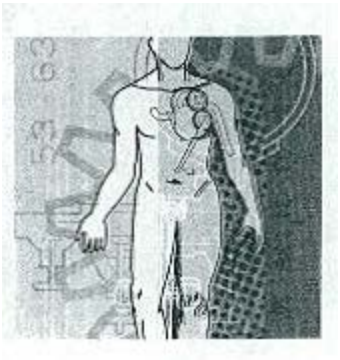


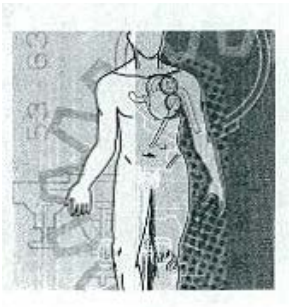
FARYAL U. BALOCH, M.D.
1775 Access Road #C
Covington, GA 30014
678.729.0003 – Phone

Thank you for choosing East Metro Rheumatology for your medical needs. Included below is material that we will need to prepare for your New Patient Visit. Please fill these forms out in print and return them to the front desk receptionist with your ID and insurance card(s). If you are currently taking medications, please provide a list of dosages to the nurse and medical provider.

Our practice offers a patient portal, a way for you to communicate with us 24 hours a day, seven days a week. It is our way of making it more convenient for you to get in touch with us from scheduling appointments to requesting prescriptions, all online at our Patient Portal. With the email that you provide us, you should receive a confirmation email that will outline the directions to set this option up for you.

Please arrive at least 30 minutes prior to your new patient appointment. We look forward to making your visit the very best possible.

Sincerely,
Staff at East Metro Rheumatology



REGISTRATION INFORMATION

First Name:_____ Middle In: ____

Last Name: _____

Date of Birth: _____ Gender: M __ F __ O __

Social Security Number _____

Email: _____

Home Address: _____

_____
City ST ZIP

Home Phone: _____

Cell Phone: _____

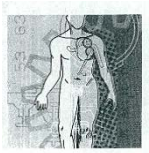
Work Phone: _____ ext: _____

Marital Status: ___Single __Married __ Partner __ Divorced __Widowed

Employment: __ Full Time __Part Time __Active Military Duty __Retired

Employer Name: _____

Pharmacy Name/Location: _____
Pharmacy Phone: _____



REGISTRATION INFORMATION

In case of an emergency, who should be notified?

First Name: _____

Last Name: _____

Relation: _____

Phone Number: _____

Other Demographics

RACE: ___ American Indian or Alaskan Native
___ Asian
___ Native Hawaiian or other Pacific Islander
___ Black or African American
___ White
___ Hispanic
___ Other Race

Are you Hispanic or Latino? _____Yes ____No

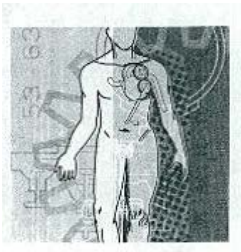
ADVANCE DIRECTIVE: Do you have

__ Do Not resuscitate

___ Living Will

___ Power of Attorney

___ Surrogate Decision Maker Not Provided (have none of the above)



MEDICAL INSURANCE INFORMATION

Do you currently have medical insurance ____Yes __ No

If yes, what is name of primary medical insurance?

_____

ID number_____

Group Number _____

Subscriber Name _____

Subscriber Date of birth: _____

Do you have secondary medical insurance ? ____Yes ___ No

If yes, what is name of primary medical insurance?

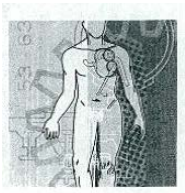
_____

ID number_____

Group Number _____

Subscriber Name _____

Subscriber Date of birth: _____



INSURANCE INFORMATION

I, the undersigned, herby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services, rendered or to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned and personally signed the particular claim.

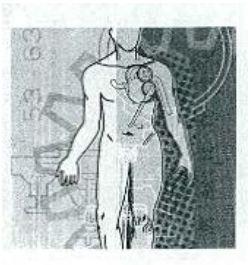
I, _____ hereby authorize _____to pay and hereby assign
(Name of Insured) (Name of Insurance Company)

directly to **EAST METRO RHEUMATOLOGY** all benefits, if any, otherwise payable to me
(Provider Name)
for his/her services as described on the attached forms. I understand I am financially responsible for

charges incurred. I further acknowledge that any insurance benefits, when received by and paid to

DR. FARYAL BALOCH will be credited to my account, in accordance with the above said (Provider Name)
agreement.

_____ _____
Authorized Signature of Subscriber Date



Acknowledgement of Receipt of NOTICE OF PRIVACY PRACTICES (Federal HIPPA Policy)

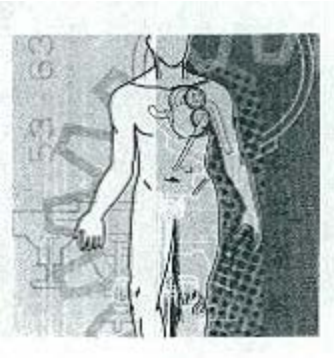
I acknowledge that I was given the opportunity to review and/or read a copy of the Notice of Privacy Practices (HIPPA Policy) and understood the notice.

_____ _____

Patient Name (Print) Parent or Authorized Agent

_____

Patient Signature



1775 Access Road #C
Covington, GA 30014
678.729.0003
Faryal U. Baloch, MD

Patient Name: _____

DOB: _____ ***Phone # _____***

I (Patient name) _____ give consent for any medical information to be release/discussed to the following individuals on my behalf. I further give consent for the same person (s) to be able to speak with the provider(s) at East Metro Rheumatology regarding my medical care and treatment.

1. Name _____

Relation to patient: _____

Contact phone #: _____

2. Name _____

Relation to patient: _____

Contact phone #: _____

3. Name _____

Relation to patient: _____

Contact phone #: _____

_____

Patient Signature **Date:**