Dr. Saeid Aryan, D.O.
Dr. David Rubin, M.D.
Phone: 817.502.7411/Fax: 817.502.7412
www.brainandback.com

New Patient Office Information

First Name: _____ Initial: _____ Last Name: _____

Address: _____ Apt# _____ City: _____ State: ____ Zip: _____

Gender: ☐ M ☐ F Date of Birth: ____/____/____ SSN # ____-____-____

Email Address: _____

Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____ Alt Phone: (____) _____-_____

Parent/ Legal Guardian if Patient is a Minor: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Name: _____ Spouse's DOB: ____/____/____ Spouse's Phone: (____) ____-_____

Race: ☐ Asian ☐ White ☐ American Indian/Alaska Native ☐ Hispanic ☐ African American ☐ Other: _____

Language: ☐ English ☐ Spanish ☐ Other: _____

Employers Name: _____ Occupation: _____

Employers Number: (_____) _____ - _____ Are you a Veteran of the US Armed Forces? ☐ YES ☐ NO

Emergency Contact

Name: _____Relationship: _____

Home #: (_____) _____ - _____ Cell #: (_____) _____ - _____ Alternate #: (_____) _____ - _____

Insurance Information

Policy Holder: _____ SSN # _____-_____-_____ D.O.B ____/____/_____

Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Primary Insurance Company: _____Policy #_____Group # _____

Second Insurance Company: _____ Policy # _____ Group #_____

How were you referred?

Referring Doctor _____ Phone Number/City_____

Primary Doctor _____ Phone Number/ City _____