
**McKinney Spine & Pain Center.**

**Afaq A Kazi, M.D.**

Phone: (469)714-0617 Fax: (469)714-0618

Date: _____ New Patient: Yes___ No___

Patient Name: _____ Sex_____

Age_____

Date of Birth: _____

Marital status: Single___ Married___ Divorced___ Widowed___

Separated___

Address:_____

_____

_

City State Zip

Home Phone: _____ Social Security

#:_____

Cell Phone: _____

Employer: _____ Work Phone

#:_____

Nearest Relative not living with

you:_____

Phone #: _____

Person to contact in case of emergency:

_____

Phone #: _____

Referring Physician:

_____

Primary Care Physician:

_____

Other Physicians:

_____

Reason for visit:

_____

Is the problem work-related? Yes___ No___ If yes, date of injury:

_____

Place of employment when injured:

_____

Current Medical Diagnosis:

_____

What form of payment will you use?

Cash___Insurance___Medicare___Medi-cal__

Primary Insurance: _____ Policy/Group #:

_____

Insured's Name: _____ Relationship:

_____

Insured's DOB: _____ SS #: _____ Employer:

_____

Primary Insurance Address:

_____

Phone #: _____ Adjuster:

_____

Secondary Insurance: _____ Policy/Group #:

_____

Insured's Name: _____ Relationship:

_____

Insured's DOB: _____ SS#:_____ Employer:

_____

2nd Insurance Address:

_____

Phone #: _____ Adjuster:

_____