Metabolic CareCenter
HOPE • TRANQUILITY • HEALING

Saad Sakkal, MD – Medical Director

New Patient Registration

Title: _____ First: _____ M/I: _____ Last: _____

Date of Birth: _____ Social Security #: _____–_____–_____ Preferred Language: _____

Gender: _____ Race: _____ Ethnicity: _____

Marital Status: _____ Employment Status: _____

Employer: _____ Occupation: _____

Home Phone: (____) _____ Mobile: (____) _____ Work Phone: (____) _____

E-Mail Address: _____

Communication Preference (*please check*): Home Phone _____ Mobile _____ Work Phone _____ E-Mail _____ Text: _____

Allow patient portal? ____No ____Yes Login ID: _____ Password: _____

Patient Home Address

Street Address:_____

City:_____ State: _____ Zip: _____

Physician / Pharmacy Information

Referring MD:_____ Phone: (____) _____

Pharmacy:_____ Phone: (____) _____

Billing / Insurance Information

Primary Insurance:

Company.: _____ Policy #: _____ Group #: _____ Plan #: _____

Secondary Insurance:

Company.: _____ Policy #: _____ Group #: _____ Plan #: _____

Date of last physical examination: _____

I, the undersigned, _____, authorize Dr. Sakkal and his staff to provide full medical examinations, acquire medical records for my care, speak to my next of kin about my medical condition or any emergencies, keep my medical records in confidence according to all state and federal regulations including HIPAA, and bill me for services. I also state that I consider myself a true partner, with rights and duties, in receiving and participating in Optimal medical care through the Metabolic Care Center.

Patient full name:_____

Signature: _____ Date: _____

"True happiness is ... to enjoy the present, without anxious dependence on the future." — Seneca, Roman philosopher