
Date

Chart Number

PLEASE PRINT CLEARLY

Patient _____ *Date of Birth* _____ *Marital Status S M D Sep W*

Home Address _____ *City* _____ *State* _____ *Zip* _____

SSN. _____ *Drivers License* _____ *Phone* _____

Employed By _____ *Occupation* _____

Business Address _____ *Bussiness Pnone* _____

Pharmacy: _____ *Email:* _____

Name of Spouse/Guardian _____ *Date of Birth* _____

Employed By _____ *Occupation* _____ *Address* _____

Patient referred by _____ *FamilyPhysician* _____

In Case of Emergency Contact _____

Insurance Information

PrimaryIns. _____ *Group#* _____ *ID#* _____

Secondary Ins. _____ *Group#* _____ *ID#* _____

Medical # _____ *Medicare #* _____

Treatment Agreement

Wafika M. Fahmy M.D
Obstetrics & Gynecology
2303 17th Street
Bakersfield, CA 93301
(Hereinafter called attending physician)

With regard to medical care and services performed or to be provided. It is agreed that the attending physician will provide medical care and service to the patient, to the best of her skills and knowledge, which medical care in the light of circumstances is possible and practical. The patient will cooperate fully with the attending physician by obtaining such medications as are prescribed, by following the instructions of the attending physician, by adhering to such treatment regimen or course of action as may be set forth and by paying all fees and charges in full as possible to warrant the outcome of such medical care and services.

By our signatures, we consent to this agreement and each acknowledge receipt of a true copy thereof.

Patient Sig. _____ *Parent/Guardian Sig* _____ *Date* _____