Lamia Gabal-Shehab, MD

Diplomat of the American Board of Urology

Adult Urology

Urologic Oncology

Cystoscopy

Urodynamics

Stone Disease

Urostym

Posterior tibial nerve stimulation

Main Office:

16300 Sand Canyon Ave

Ste. 405

Irvine, CA 92618

Office: 949.825.7650

Fax: 949.825.7648

www.drgabal.com

Dear New Patient,

Welcome to Our Practice!

We look forward to seeing you soon. If you have any questions prior to your visit, do not hesitate to call our office.

Please remember to bring:

1. Complete New Patient Packet
2. Insurance Cards
3. Referral if required by your Insurance
4. Lab results (MUST HAVE ON HAND)
5. Radiology Testing (Reports) (MUST HAVE ON HAND)
6. Updated Medication List (MUST HAVE ON HAND)

Please arrive 10 to 15 minutes prior to your scheduled appointment for registration.

Sincerely,

The Scheduling Staff

Lamia L. Gabal-Shehab, MD

Appointment Date:

Dr. Gabal, M.D.

PATIENT REGISTRATION FORM

Please Print & Complete in Full)

MRN: _____ DATE: _____

PATIENT INFORMATION:

Social Security #: _____-_____-_____ Email Address: _____

First Name: _____ M.I._____ Last Name: _____

Address: _____ City:_____ State: _____ Zip: _____

Date of Birth: ____ /____/_____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Home Phone: (_____) _____-_____ Work: (_____) _____-_____ Cell: (_____) _____-_____

Race: ☐African American ☐Asian ☐Caucasian ☐ Hispanic ☐Native American ☐Other

Ethnicity: _____ Preferred Language: _____

If Patient is a child, lives with: ☐ Both Parents ☐Mother ☐Father ☐Other: _____

Name of Person with Whom Child Lives: _____

RESPONSIBLE PARTY IF OTHER THAN PATIENT

Social Security #: _____-_____-_____ Responsible Party Name: _____

Address: _____City: _____State: _____ Zip:_____

Home Phone: (_____)_____-_____ Work: (_____)_____-_____

Date of Birth: _____/_____/_____ Sex: ☐ Male ☐ Female Relationship: _____

REFERRED BY:

Referring Provider: _____ Phone: (_____) _____-_____
PCP Provider: _____ Phone: (_____) _____-_____

IN CASE OF EMERGENCY:

Relative/Friend: _____ Relationship: _____
Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

PHARMACY INFORMATION:

Pharmacy: (Name, Street Name & Phone, if known): _____

The above information is true to the best of my knowledge. Professional fees are due at the time services are rendered. These include but are not limited to co-pays, deductibles, self pay and all discount plan payments. I authorize my insurance benefits to be paid directly to the provider. I understand that I am financially responsible for all balances that are not covered by my insurance plan. I also authorize Lamia L. Gabal-Shehab MD Inc. and the insurance company to release any information required to process my claims. If it becomes necessary to collect fees through the services of an attorney or collection agency, I understand this will increase by balance approximately 30 percent.

PATIENT SIGNATURE: _____ DATE: _____