Beverly Hills Digestive Care

Shahab Mehdizadeh, M.D.

DATE

PATIENT LAST NAME	FIRST NAME	MI

SEX	BIRTH DATE	AGE	SOCIAL SECURITY NUMBER	HOME TELEPHONE	CELL PHONE

IF PATIENT IS MINOR, GUARDIAN'S FULL NAME	E-MAIL ADDRESS

YOUR REGULAR PHYSICIAN'S FULL NAME	OFFICE TELEPHONE NUMBER

REFERRED BY	TELEPHONE NUMBER

EMERGENCY NOTIFICATOIN

PATIENT'S DRIVER LICENSE NO.	NAME	RELATIONSHIP

TELEPHONE	STREET ADDRESS	CITY, STATE	ZIP CODE

EMPLOYMENT INFORMATION

EMPLOYER NAME	WORK NUMBER

STREET ADDRESS	CITY, STATE	ZIP CODE

OCCUPATION

INSURANCE COMPANY (PRIMARY)

NAME	MEMBER OR MEDICARE NUMBER

INSURANCE COMPANY ADDRESS

GROUP NUMBER	SUBSCRIBER NAME (IF NOT PATIENT) AND DATE OF BIRTH	MM	DD	YY	RELATION

INSURANCE COMPANY (SECONDARY)

NAME	MEMBER OR MEDICARE NUMBER

INSURANCE COMPANY ADDRESS

GROUP NUMBER	SUBSCRIBER NAME (IF NOT PATIENT) AND DATE OF BIRTH	MM	DD	YY	RELATION

THIRD PARTY BILLING (OR REMARKS)

- AUTHORIZATION TO PAY -

I, _____ hereby authorize my insurance / Third party listed above or proviced at time of visit to pay directly to Shahab Mehdizadeh, M.D. the surgical and or medical benefits, if any, otherwise payable for this services as described on my insurance form hereof, but not to exceed the charges for those services. I authorize my physician to release any information regarding my care, to my insurance provider, for the purpose of benefit determination. I understand that I am financially responsible for those chargers not paid by my insurance.

Date: _____ Signed: _____