Dennis Sarabi, M.D., Inc.

400 Newport Center Drive
Newport Beach, CA. 92660
(949) 706-1114 Fax: (949) 706-3286

Today's date:	E-mail address:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address: City, State, Zip:	Social Security No.:	Home phone: Cell phone: Work phone:

Medication Allergies:	Drivers License No.:	Primary Care Physician:	Physician Phone No.: ( )

Occupation:	Employer:	Employer Phone No.: ( )

Referring Doctor:	Phone:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home Phone No.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer Phone No.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Subscriber's name:	Subscriber's S.S. No.:	Birth date: / /	Group No.:	Policy No.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:		Group No.:	Policy No.:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home Phone No.: ( )	Work Phone No.: ( )

The above information is true to the best of my knowledge. I hereby assign my insurance benefits be paid directly to Dr. Dennis Sarabi and/or any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. Dr. Dennis Sarabi reserves the right to charge a 1% finance charge on all accounts over 90 days. I also hereby authorize Dr. Dennis Sarabi to release all information to insurance carriers upon request. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient/Guardian signature _____ Date _____

*Effective January 1, 2013 there will be a $25.00 charge for each office visit appointment that is not cancelled within 24 hours and a $50.00 charge for all testing appointments that are not cancelled within 24 hours prior to the scheduled time.