Cory A. Waldman, MD

Internal Medicine & Cardiovascular Diseases
435 North Roxbury Drive, Suite 300
Beverly Hills, California 90210
Telephone (424) 239-1499 Fax (310) 274-1073

NAME_____D.O.B._____AGE_____

RESPONSIBLE PARTY _____MARITAL STATUS: S M W D

HOME ADDRESS_____CITY _____ZIP_____

HOME TELEPHONE _____WORK PHONE_____

CELL/MOBILE_____EMAIL_____

EMPLOYER _____OCCUPATION _____

SOCIAL SECURITY NUMBER_____DRIVERS LICENSE NUMBER_____

SPOUSE'S NAME_____REFERRED BY_____

EMERGENCY CONTACT _____PHONE _____

PRIMARY INSURANCE COMPANY_____

ID# and GROUP#_____

SUBSCRIBER'S NAME_____SUBSCRIBER'S DOB:_____

SECONDARY INSURANCE COMPANY_____

ID# AND GROUP#_____

SUBSCRIBER NAME_____SUBSCRIBER'S DOB:_____

We are committed to providing the best possible healthcare for all patients. In order to do so we need your assistance and cooperation. This practice has established a firm financial policy that must be adhered to. Payments are accepted by check, cash, and credit card. As a courtesy, we electronically bill your insurance company for you. However the ultimate responsibility of paying for medical services received is yours. This means that if your insurance company does not pay for services in full, or if your claim is denied for whatever reason, you must pay any amount that may become due.

Our policy regarding your health insurance: Your medical insurance is a contract between you and your insurance carrier. For those plans that we are not contracted with ("out of network"), we are not bound in any way to the terms and conditions of your policy. Our professional fees generally fall within the range of most insurance company's Usual and Customary Rate tables. This means that our fees may not be in alignment with companies that pay based on an arbitrary schedule of fees. Such "schedules" often bear no relationship to the Usual and Customary Rates that apply to this region or community. Some services performed may not be covered under the benefits provisions of certain insurance policies. Some insurance companies arbitrarily choose certain services they will not cover. Questions concerning medical benefits can be addressed by contacting the customer service number listed on your insurance card. As a patient, it is in your best interest to know and understand your insurance plan benefits. We endeavor to provide all courtesy regarding insurance billing but want to emphasize that our relationship is with you, not your insurance companies. All charges incurred will be the responsibility of the patient. We realize that temporary financial problems may arise and invite you to contact us immediately to make arrangements with regard to your account.

- I hereby assign to the doctor(s) whose name(s) appear above all money to which I am entitled for all medical and/or surgical consultation and/or treatment provided by said doctor(s). I understand that I am financially responsible to said doctor(s) for all charges not covered by this assignment.
- I hereby authorize the doctor(s) whose name(s) appear above to furnish my insurance company all information which the company may request concerning my present illness or injury.
- I hereby authorize any doctor, hospital, or other medically related facility or institution that has any records and/or X-rays and imaging pertaining to me or my health and prior medical history to release such records and/or X-rays and imaging to the doctor(s) named above.
- Should an attorney be employed or suit commenced to collect payment of my account, I agree to pay such additional sum as the court may adjudge reasonable as attorney's fees and costs in said suit.
- It is my responsibility to provide the office with updated demographic information including but not limited to address changes, contact phone numbers, primary email address, and medical insurance carrier(s). I will notify the office if insurance has changed, and will provide an updated insurance card at the time of service with a valid photo ID.
- A photostatic copy of this authorization shall be as valid as the original.

Patient Signature_____ **Date**_____

Parent or Guardian_____ Date_____

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Name:_____D.O.B._____

General Chronic Medical Problems (IE; high blood pressure, diabetes, high cholesterol, heart disease, cancer history)

Surgical History (procedure, and date of procedure)

Drug Allergies and Reaction (example: Penicillin / Rash)

Medications	Name of Medicine	Dosage (IE: 20 mg)	When taken (IE: once daily)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Pharmacy Name:_____ Pharmacy Phone Number:_____

Patient Signature_____ **Date**_____

Parent or Guardian_____ Date_____

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Name:_____D.O.B._____

Social History
Tobacco Use (please circle): Yes No Former

If Former or Active Tobacco User:
year quit_____ packs per day on average_____ Total Years Smoked_____

Alcohol Use (please circle): Yes No Socially

If daily alcohol use, how many drinks per day on average_____
Type of alcohol (wine, beer, liquor)_____

Illicit Drug Use (please circle): Yes No Former If yes, what current drugs_____

Family Medical History

Relation	Major Medical Problems (IE colon cancer, heart disease)	Living (yes, no)	If deceased, age of death
Mother			
Father			
Brother			
Brother			
Sister			
Sister			

Other Physicians

Specialty of Physician	Name of Physician	Phone Number

Patient Signature_____ **Date**_____

Parent or Guardian_____ Date_____

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HIPAA Notice of Privacy Practices

Cory A. Waldman, M.D., APC
435 N. Roxbury Dr. Suite #300
Beverly Hills, CA 90210
Privacy Officer: Cory A. Waldman, M.D. (424) 239-1499

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I

further acknowledge that a copy of the current notice will be posted in the physician's offices, and that a

copy of any amended Notice of Privacy Practices will be available at each appointment. If I would like to

receive a copy of any amended Notice of Privacy Practices it will be available to me upon request or at the medical office.

Print Name:_____

Signature:_____ **Date**:_____

If not signed by the patient, please indicate relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient

Patient Signature_____ **Date**_____

Parent or Guardian_____ Date_____