DAVID RAMIN, MD.
9025 Wilshire Blvd., # 210
Beverly Hills, CA 90211

## PATIENT INFORMATION

| | |
|---|---|
| Patient Name | Address |
| Social Security Number | City State Zip |
| Date of Birth / Sex ☐ M ☐ F | Home Phone / Work Phone |
| Marital Status (check one ) ☐ Single ☐ Married ☐Other | Cell/ Beeper |
| Employment Status (check one)<br>☐Full Time ☐ Student<br>☐Part Time ☐Not Employed<br>☐Self Employed ☐Retired (date) _____/_____/_____ | E-mail address<br><br>Referred by |
| Patient Employer/ Union/ Guild | |
| Address | |
| City State Zip | Phone |

## GUARANTOR

| | |
|---|---|
| Name of Person who is Financially Responsible for Patient (if different from patient) | |
| Patient Relationship to Above | Employer |
| Social Security Number | Date of Birth |

## INSURANCE INFORMATION

| | |
|---|---|
| Insurance 1 Insurance Name | Insurance2 Insurance Name |
| Policy Group | Policy Group |
| Participant (insured) Name (if different) | Participant (insured) Name (if different) |
| Relationship to Patient | Relationship to Patient |

Is the Patient eligible for Medicare benefits?
(check one) ☐Yes ☐ No (if Yes) Has the patient assigned benefits to an HMO? ☐Yes ☐ No

Does the patient have an Advance Directive? (check one)
☐ Yes ☐ No (if No) Would the patient like information on Advance Directives? ☐ Yes ☐ No

## EMERGENCY CONTACT

| | |
|---|---|
| Emergency Contact 1 Name | Emergency Contact 2 Name |
| Relation to Patient | Relation to Patient |
| Home Phone | Home Phone |
| Work Phone | Work Phone |

I understand that I am responsible for all services rendered and applicable fees. Co-payments are required at the time of service. My insurance will be billed as a courtesy and any amount not paid will be my responsibility.

_______________________________ _______________
Signature Date