Ashkan Naraghi, MD **Dan Naim, MD**
9001 Wilshire Blvd., Suite 200, Beverly Hills, CA 90211

Patient Registration

Please Print

Date	New	Add	Change

Personal Information

Patient Name (Last,First)	Address
Social Security	City, State Zip Code
Date of Birth / Sex M F	Home Phone Work Phone
Martial Status Single Married Other	Cell Phone
Primary Language	E-Mail Address

Employment Information

Employment Statue (Circle One)

Full Time Part Time Self Employment Not Employed Retires (Date) Student

Name of Employer/Union/Guild	Occupation
Employer Address	Employer City, State, Zip

Additional Information

Driver's License State/ID	Mother's Maiden Name	Place of Birth City & State
Driver License #/ID#	Patient Maiden Name	
Pharmacy Name	Pharmacy Phone & Fax	

Emergency Contact

Name	Relationship	Home Phone	Work Phone
Address, City	State, Zip Code	Legal Guardian Yes NO	Cell Phone

Guarantor Information

Name of Person who is Financially Responsible for the Patient		Relation to Patient
Employer	Social Security Number	Date of Birth

Please Continue on Back ➔

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Insurance Information			
Primary Insurance PPO/POS/HMO		Subscriber ID#	Phone Number
Effective Date	Relationship to Subscriber	Group #	Group Name
Secondary Insurance PPO/POS/HMO		Subscriber ID#	Phone Number
Member Effective Date	Relationship to Subscriber	Group #	Group Name
Insurance Information (Medicare Patients Only)			
Subscriber ID# Relationship to Subscriber Part A Eff Date Part B Eff Date			
Have you assigned your benefits to a HMO? (If Yes) Medical Group Name Yes NO			

PLEASE SIGN SO WE MAY HAVE YOUR INSURANCE AUTHORIZATION ON FILE

I authorize any holder of medical or other information about me to release to the above insurance company(s) any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment.

SIGNATURE:_____ DATE:_____

Please provide your insurance card (s) and driver's license to the receptionist along with this form.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1966 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment form third party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change it Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:_____

Relationship to Patient:_____

Signature:_____

Date:_____

OFFIEC USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below.

Date:_____ Initials:_____

Reason:_____

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To My Patients,

Rescheduling Appointments

We understand that you may at times need to reschedule an appointment. Please call the office as soon as possible but **at least 24 hours** before your appointment in order for us to care for other who need to be seen.

Missed Appointments

If you miss an appointment or cancel with less than 24 hours' notice, there will be a charge of $50. This charge is not covered by your insurance and is your responsibility. The fee must be paid prior to any future visits.

Please sign and return this letter to our office to acknowledge receipt.

_____

Print Name

_____

Signed/Date