ELEVATE
HEALTH GROUP
A MEDICAL CORPORATION

Garen DerHartunian, M.D.
Narbeh Tovmassian, M.D.
Internal Medicine

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Today's date: / / 2015

PATIENT INFORMATION

Patient's Last Name: First: Middle:		❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital Status (circle one) Single / Married / Divorced Separated / Widowed
Birth Date: Age / /	Email:	Social Security No: Driver's License No: CA		Home Phone: ( )
Street address: Apt No:		Sex: ❑ Male ❑ Female		Cell Phone: ( )
City:		State:		ZIP Code:
Patient's Occupation:	Employer's Name:			Employer Phone: ( )
Employer's Address:				
Person To Notify (Name of relative not residing with you): Phone: Relationship:				
How did you hear about us (Please specify):				
Preferred Language: ❑ English ❑ Spanish ❑ Armenian ❑ Chinese ❑ Korean ❑ Japanese ❑ Farsi ❑ Russian ❑ Other				
Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ White ❑ Other Pacific Islander				
Ethnicity: ❑ Hispanic or Latino ❑ Non-Hispanic or Latino				

INSURANCE INFORMATION

Name of Primary Insurance Company:	Address:		Insurance phone no.: ( )
Policy or Certificate No:	Group No:	Effective Date: / /	Policyholder's Name:
Name of Secondary Insurance Company:	Address:		Insurance phone no.: ( )
Policy or Certificate No:	Group No:	Effective Date: / /	Policyholder's Name:

FINANCIAL RESPONSIBILITY

- I consent to treatment necessary for my care.
- I authorize the release of all medical records to other consulting physicians and to my insurance company.
  - I allow fax transmittal of my medical records, if necessary.
  - I acknowledge full financial responsibility for services rendered by Garen Derhartunian, M.D. and Narbeh Tovmassian, M.D.
  - I acknowledge full financial responsibility for missed appointments without 24 hours advanced notice.
  - I acknowledge that there will be a charge to obtain copies of records and to fill out medical forms.
  - I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
  - I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.
  - I further authorize and request that insurance payments be made directly to Garen Derhartunian, M.D. and Narbeh Tovmassian, M.D.
  - I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

_____ _____

Patient/Guardian signature Date