BEVERLY HILLS NEUROLOGY

Distinctly Superior Medical Care

☐ **RONALD M. ANDIMAN, M.D.** ☐ **A. ANDREW MOROVATI D.O.**

PATIENT INFORMATION

LAST NAME	FIRST NAME	DATE	
ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE	CELL PHONE	DRIVER LICENSE #	
SOCIAL SECURITY #	SEX M F	DATE OF BIRTH	AGE
MARITAL STATUS (CIRCLE ONE) SINGLE MARRIED DOMESTIC PARTNERSHIP DIVORCED WIDOWED			
EMERGENCY CONTACT	PATIENT CONFIDENTIAL EMAIL ADDRESS		
ADDRESS	PHARMACY NAME AND PHONE NUMBER		
PHONE NUMBER	REFERRING PHYSICIAN NAME AND PHONE NUMBER		
RELATIONSHIP TO PATIENT			

INSURANCE INFORMATION

PRIMARY INSURANCE	ID #	RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER
SECONDARY INSURANCE	ID #	RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER

LIFE TIME INSURANCE AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize B.H.N. to release for insurance purposes any requested information related to my evaluation and treatment.

AUTHORIZATION TO PAY

I hereby authorize B.H.N. to bill my insurance for services rendered, and that I am financially responsible for the charges NOT covered by my insurance plan, including co-payments, deductibles, and co-insurance. In the event that there is an unpaid balance by my insurance, I guarantee to pay such balance promptly. I understand that I am responsible for any collections agency charges and bank fees for returned checks.

SIGNATURE:____ **DATE:**____