PATIENT INFORMATION SHEET

Sasan Najibi, M.D., F.A.C.S. **John Conrad, M.D., F.A.C.S.**

LAST NAME	FIRST			M.I.
HOME PHONE	CELL PHONE/ALTERNATE NUMBER		WORK PHONE	
ADDRESS	CITY		ZIP	
SOCIAL SECURITY NO.	DATE OF BIRTH	MARITAL STATUS	AGE	SEX
EMERGENCY CONTACT PERSON/ PARENT OR GUARDIAN	RELATIONSHIP TO PATIENT		CONTACT'S PHONE NO.	
EMPLOYER	ADDRESS (CITY & STATE)		ZIP	
REFERRING PHYSICIAN OR PARTY	PHYSICIAN'S ADDRESS (CITY & STATE)		PHYSICIAN'S PHONE NO.	

INSURANCE THIS INFORMATION MUST BE COMPLETED OR WE WILL REQUIRE PAYMENT AFTER SERVICES HAVE BEEN RENDERED

PRIMARY INSURANCE			
ADDRESS	CITY	STATE	ZIP
INSURED PARTY	DATE OF BIRTH	RELATIONSHIP TO PATIENT	
POLICY NO/IDENTIFICATION NO.	GROUP NO.	EFFECTIVE DATE	
SECONDARY INSURANCE			
ADDRESS	CITY	STATE	ZIP
INSURED PARTY	DATE OF BIRTH	RELATIONSHIP TO PATIENT	
POLICY NO./IDENTIFICATION NO.	GROUP NO.	EFFECTIVE DATE	

PLEASE NOTE: YOU ARE RESPONSIBLE FOR ALL CO-PAYMENTS AND DEDUCTIBLES. PLEASE BE PREPARED TO PAY FOR YOUR CO-PAYMENTS AT THE TIME OF YOUR VISIT.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO L.A. VASCULAR & ENDOVASCULAR SURGERY FOR THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR PROFESSIONAL SERVICES RENDERED TO ME. I UNDERSTAND THAT IT IS THE PATIENT/GUARANTOR RESPONSIBILITY TO KNOW IF L.A. VASCULAR & ENDOVASCULAR SURGERY IS 'IN' OR 'OUT' OF NETWORK FOR MY INSURANCE. IF MY INSURANCE PROVIDER IS OUT OF NETWORK AND I CHOOSE TO BE TREATED BY L.A. VASCULAR & ENDOVASCULAR SURGERY, I MAY BE RESPONSIBLE FOR HIGHER OUT-OF-POCKET CHARGES. THE UNDERSIGNED AGREES THAT I AM INDIVIDUALLY OBLIGATED TO PAY THE FULL CHARGES OF ALL SERVICES RENDERED TO ME. I FURTHER AGREE IN THE EVENT OF NON-PAYMENT, TO BEAR THE COST OF REASONABLE LEGAL FEES SHOULD THIS BE REQUIRED.

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DATE (mm/dd/yyyy) SIGNATURE OF PATIENT, OR PARENT IF MINOR

I HEREBY AUTHORIZE L.A. VASCULAR SURGERY TO DISCLOSE WHEN TREATED BY THE ABOVE MENTIONED INSURANCE CARRIERS OR ITS REPRESENTATIVES, TRANSMISSIONS OF PORTIONS OF PATIENT'S MEDICAL RECORDS TO PHYSICIAN'S DATA CORPORATION FOR ELECTRONIC STORAGE AND RETRIEVAL. ANY AND ALL INFORMATION WITH RESPECT TO ANY ILLNESS (ES) OR INJURY (IES), MEDICAL HISTORY OF TREATMENT AND COPIES OF ALL MEDICAL RECORDS, A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED EFFECTIVE AND VALID AS THE ORIGINAL.

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DATE (mm/dd/yyy) SIGNATURE OF PATIENT, OR PARENT IF MINOR