REGISTRATION FORM

(Please Print)

Today's date:						
PATIENT INFORMATION						
Last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Dr.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Ethnicity:	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Home phone number:		Cell phone number:				
Email Address:		Social Security number:				
Address:						
City:	State	Zip Code:				
Occupation:		Employer: Employer phone number:				
Emergency Contact:		Relationship: Phone number:				
Insurance Co:						
Subscriber Name/DOB:						
□ I **do** □ I **do not** give permission to leave relevant medical information on my answering machine or voice mail.						
□ I **do** □ I **do not** want my medical information mailed to my house address on file.						

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor/ambulatory surgery center and is not a substitute for payment. Some companies have fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amounts, co-pays, co-insurance, or any other balance not paid for you by your insurance. If the account is not paid in full and prior arrangements have not been made, your account(s) may be referred to a collection Agency. In the event that your account is referred to an Agency, you will be responsible for all attorney's and/or collection fees.

I directly assign all medical/surgical benefits to PEYTON P. BEROOKIM, M.D., INC. and understand that I am financially responsible for all charges not covered by my insurance benefits. I authorize payment to be made to the provider. In the event that the payment is made to the policyholder, I agree to submit payment in full to this office immediately. If I receive a check from my insurance, I agree to immediately endorse the back of the check to Peyton P.Berookim, M.D., Inc. and send it to the medical office at 150 N Robertson Blvd. Suite 204, Beverly Hills, CA 90211. I understand that this Entity requires Advance Payment for certain in-office and outpatient procedures. As a patient, I am required to be familiar with my Insurance coverage and its policies and know my co-pay, coinsurance, deductible, total out of pocket expense, effective date of coverage, pre-existing conditions AND whether I am receiving service from a contracted or out-of-network physician or other healthcare provider/facility. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. I have read and understand the information on this form. I certify the information is true and correct to the best of my knowledge. **I have reviewed the above Policies & Agreements and hereby agree to comply with ENTITY Policies**

Signature: _____ **Date:** _____