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Phone 949 706-7706 Fax 949 706-7707

Name: ____ Today's Date:________________________

Driver License # _________________________ Social Security # _______-____-________

Sex: ________________ Date of Birth: ____________________ Age: __________________

Mailing Address: ____

City: ____ State: __________________ Zip: ________________

Email Address: ____

Home Phone: ____________________________ Cell Phone : _______________________ Fax: ____________________

Employer Name: ____ Telephone: ________________________________

Occupation : ____

Spouse's Name: ____ Telephone: ________________________________

Who may we thank for referring you to our office? ____

Who may we contact in case of an emergency?

Name: ____ Telephone: ________________________________

Who is your primary care physician?

Name: ____ Telephone: ________________________________

We bill your insurance, but you are responsible for Co-pay at time of your office visit.
I hereby authorize Dr. Moattari to apply for benefits on my behalf for covered services render by him ,or by his order. I request that payments from my insurance company be made directly to Dr. Moattari. I certify that the information I have reported with regard to my insurance coverage is correct.
I authorize the release of any medical information necessary to process the claims. I permit a copy of this authorization to be used in the place of the original. This authorization may be revoked by either me or my insurance company at any time.

Signature: ____ **Date:** ___________________________

I understand that I am responsible for obtaining any prior authorization from my insurance company for office visit and agree that, I am responsible for the payment of all balances due for any professional/medical services or treatments rendered to me which was not paid by insurance ie. Co- Pay, deductible, etc. . I certify this information is true and correct to the best of my knowledge. I agree to notify Dr. Reza Moattari of any changes in my health insurance and the above information.
Signature: ____ **Date:** ___________________________