Advanced California Medical Center, Inc
Deena Tajran, M.D.

Patient Registration **(Please Print Clearly)** Date of 1st visit: ______________________________

Patient's Name: ____
Last First Middle

Home Address: ____
Street Apt. # City State Zip

Home Phone: (______) ______________________ Cell Phone: (______) ______________________

Work Phone: (______) ______________________ Ext. E-mail: ______________________

Date of Birth: ______________________ Marital Status: M W S D

Social Security #: ______________________ Drivers Lic: ______________________

Employer: ______________________ Occupation: ______________________

Employer Address: ____
Street City State Zip

SPOUSE OR RESPONSIBLE PARTY INFORMATION

Name: ____ Relationship: ______________
Last First Middle

Social Security #: ______________________ Date of Birth: ______________________

Home Address: ____
(If different from above) Street City State Zip

Employer: ______________________ Occupation: ______________________

Employer Address: ____
Street City State Zip

Work Phone: (______) ______________________ Ext. E-mail: ______________________

Emergency Contact: ______________________ Phone: (______) ______________________

How were you referred to our office?: ______________________________

THIS SECTION MUST BE COMPLETED *INSURANCE INFORMATION* *(PLEASE LIST ALL YOUR MEDICAL INSURANCES)*

Primary Insurance: ______________________ PPO___Tricare___PR/STD Othr___ M-Cal Molina CHG UnionPac Care1st
(circle one)

Subscriber Name: ____
Last First Middle

Policy #: ______________________ Group #: ______________________

Primary Physician(PCP): ______________________ Co-Pay: $____________

Secondary Insurance: ______________________ PPO___Tricare___PR/STD Othr___ M-Cal Molina CHG UnionPac Care1st
(circle one)

Subscriber Name: ____
Last First Middle

Policy #: ______________________ Group #: ______________________

ASSIGNMENT/AUTHORIZATION

I hereby authorize payment of insurance benefits to be made to Advanced California Medical Center, Inc./Deena Tajran, MD for services provided to me or members of my family. **I understand that I am financially responsible for all charges not covered by insurance.** In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I give my permission to Advanced California Medical Center, Inc./Deena Tajran, MD to verify any information above. I authorize the release of any medical information necessary to process my insurance claims. I agree to release pertinent demographic and insurance information to a specialist and/or health services provider in the event that it is necessary in my course of treatment. **It is my responsibility to confirm with my insurance group that I am able to receive services from this provider, if determined this is a non-participating provider I will be fully responsible for payment of services received.**

I certify that the above information is true and correct to the best of my knowledge, and I consent to any medical or surgical treatment rendered the patient under the general or special instructions of the physician.

Signature: ______________________________ Date: ______________________