

PATIENT INFORMATION

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**Thyroid and Parathyroid Surgery**

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**PLEASE PRINT**

**Patient Name:** \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

*If Patient is a Minor, Name of Parent/Responsible Party:* \_\_\_\_\_

**Address:** \_\_\_\_\_ **Apt#:** \_\_\_\_\_ **Marital Status:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Date of Birth** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Age:** \_\_\_\_ **Social Security #** \_\_\_\_\_

**Driver's License #** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Home Telephone #** (\_\_\_\_) \_\_\_\_\_ **Employer Name:** \_\_\_\_\_

**Cell Phone #** (\_\_\_\_) \_\_\_\_\_ **Work Telephone #:** (\_\_\_\_) \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Insurance Company:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **ID.No/SSN:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_ **Insured Name:** \_\_\_\_\_

**Telephone #:** (\_\_\_\_) \_\_\_\_\_ **Insured Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Whom shall we thank for referring you?** \_\_\_\_\_

**Personal Physician:** \_\_\_\_\_ **Telephone #:** (\_\_\_\_) \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_ **Zip Code:** \_\_\_\_\_

**AUTHORIZATION:**

May we send your physician a report of our findings? Yes \_\_\_\_\_ No \_\_\_\_\_

I authorize the release of medical information to my insurance company: Yes \_\_\_\_\_ No \_\_\_\_\_

**BILLING POLICY:**

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED, unless your physician is contracted with your insurance carrier (including Medicare). The insurance company is hereby authorized to pay all benefits to my attending physician. If special arrangements for payment are needed, they must be made prior to services; please ask for the office manager. We do not accept Medi-cal or legal liens.

**I have read the above policy and understand my financial responsibility.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_