MARK DAVIDSON, M.D. Inc.

PATIENT INFORMATION

CEDARS-SINAI MEDICAL TOWERS
8631 W. THIRD STREET,STE. 1135 EAST
LOS ANGELES, CA 90048

PH# : (310) 855-0222 Fax#: (310) 652-1905

THIS SECTION REFERS TO PATIENT ONLY

NAME	SEX	AGE	D.O.B.	MARITAL STATUS ☐ SINGLE ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ MARRIED
ADDRESS		S.S. NUMBER		
CITY STATE	ZIP	EMPLOYER NAME		
HOME PHONE ( ) CELL PHONE ( )	WORK PHONE ( )	ADDRESS		
CALIFORNIA DRIVER'S LICENSE NO.	OCCUPATION	CITY	STATE	ZIP
REFERRING PHYSICIAN	ADDRESS	CITY	ZIP	PHONE ( )
NAME OF PERSON TO BE NOTIFIED IN EMERGENCY	ADDRESS	CITY	ZIP	PHONE ( )
DO YOU HAVE ANY ALLERGIES TO MEDICATION? ☐ YES ☐ NO IF YES, WHICH ONE?				

INSURANCE INFORMATION

HEALTH PLAN

ELIGIBILITY VERIFICATION ☐ YES ☐ NO

AUTHORIZATION NEEDED ☐ YES ☐ NO

☐ PVT. INS. ☐ MEDICARE ☐ MEDI-CAL ☐ MEDI-MEDI ☐ W/C ☐ P.I. ☐ CASH ☐ CREDIT CARD

ACCT NO. EXP. DATE

NAME OF INSURANCE COMPANY *PRIMARY*	NAME OF INSURANCE COMPANY *SECONDARY*
ADDRESS	ADDRESS
NAME OF INSURED	NAME OF INSURED
POLICY HOLDER (COMPANY NAME GROUP) / GROUP NO.	POLICY HOLDER (COMPANY NAME GROUP) / GROUP NO.
POLICY OR CERTIFICATE NO./S.S. NO. / EFFEC. DATE	POLICY OR CERTIFICATE NO./S.S. NO. / EFFEC. DATE
PATIENT IS: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER (SPECIFY) _____	PATIENT IS: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER (SPECIFY) _____

☐ MEDI-CAL I.D.#
☐ MEDI-CARE I.D. #

CO-INSURANCE ☐ YES ☐ NO $_____

HAVE YOU MET YOUR DEDUCTIBLE? ☐ YES ☐ NO $_____

ACKNOWLEDGEMENT AND AUTHORITY FOR TREATMENT AND PAYMENT

I consent to treatment as necessary or desirable to the patient named above, including but restricted to whatever drugs, medicine, performance of operations, laboratory , x-ray or other studies that may be used by the attending doctor, his nurse or qualified designee.

I further understand that the qualified designee in some cases will be the Assistant to the Physician, also call P.A. An Assistant to the Physician means a person who is a graduate of an approved program of instructions in Health Care and is approved by the Board to perform direct patient care services under the supervision of a Physician.

I also acknowledge full responsibility for such services and agree to pay for them, in full, AT THE TIME OF SERVICES, If payment is not received within sixty (60) days of service , a finance charge of 1 1/2% per month will be applied to the unpaid balance. If the physician must use a collection agency/attorney/or court to collect its charges, then I will pay reasonable attorrney fees, and costs, incurred in collecting same, regardless of insurance coverage.

I hereby authorize payment directly to **Mark Davidson. M.D. Inc.** of the Medical Expenses benefits otherwise payable to me but not exceed my indebtedness to said physician on account of the enclosed charge.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or the party who accepts assignment below.

SIGNED _____ DATE _____

INSURED OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the designated physician or supplier for services rendered.

SIGNED _____