Dr. Karen Sandler

PATIENT INFORMATION FORM

Patient Name:____ DOB:______________________

Patient SS#:____ Member SS#:________________

Home Address:____

____

Home Phone Number:______________________________ Work Number:_______________

E-mail Address:____

Your Occupation:____

Work Address:____________________________________ City/State/Zip:_______________

Spouse/Significant Other Name:____
Spouse/Significant Other Phone:____

Patient Referral Information:
Referred by:____
If referred by a friend, may we thank him or her? ___Yes ___No
Name of publication advertisement was seen in:_______________________________________
Name of Internet Directory or Website by which you found Dr. Sandler:______________________
Name of other physicians who care for you:____
____

Emergency Contact:
Name of person not living with you:____
Relationship:____
Street Address:______________________________Apt#.____City/State/Zip:_________________
Home Phone Number:________________________Work Phone Number:____________________

Patient Insurance Information:

Name of Insurance:_____________________________________Phone Number:________________

Who will be financially responsible for this medical bill?__________________________________

ASSIGNMENT OF BENEFITS: FINANCIAL AGREEMENT

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Karen Sandler, D.O., and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fee. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original

Date:_________________________ **Signature**:____

FAX FORM TO: 310-659-1862 ~~~ OFFICE PHONE: 310-854-2401