Jeremy S. Fine, MD
2080 Century Park East, Ste. 1807
Los Angeles, CA 90067
(310) 556-8898

Acct. #_____

Today's date _____/_____/_____

Last name:_____First:_____MI:____
Home
Address:_____Gender: M_____F____
(*No P.O. Boxes Accepted*)

_____ ❑ **Home. tel**.(_____)_____

City:_____State:_____Zip: _____ ❑ **Work. tel**.(_____)_____

Date of birth:_____/_____/_____ Age_____ ❑ **Cell. tel**.(_____)_____

SSN:_____-_____-_____ E-Mail: _____

Driv. lic. #_____State_____ ↥ **Please ☒ preferred**

Occupation:_____ **contact number above.**

Employer Info: Name:_____

Address:_____ State____ Zip_____

Marital/Union status: M__ S__ D__ W__ Spouse's name_____

Emerg, contact:_____Relation_____Phone(___)_____

Emerg. contact #2_____Relation_____Phone(___)_____

Who referred you to our office? _____

PRIMARY INSURANCE PLAN:

Insurance Co.:_____Effective date_____

Plan/number_____Insured name_____

Annual deductible_____

Policy #_____Group #_____ Insured's patient #_____

Patient's relationship to insured_____Other info_____

SECONDARY INSURANCE:

Insurance co_____Effective date_____

Plan/Number_____Insured name_____

Policy #_____Group #_____ Insured's patient #_____

PAYMENT IS DUE ON THE DATE OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.

I authorize Dr. Fine to bill my insurance company and/or Medicare and assign benefits payable to him. I understand that some services (even necessary, routine or preventative measures) may or may not be covered by my policy and that I will be financially responsible for these services *if* deemed unpayable by my insurance carrier. Should, after Dr. Fine's due diligence, my insurance company fail to pay within 90 days for *any* reason, I will assume full responsibility for any balance. A $100.00 fee may be applied for missed appointments without proper notice (preferably 24 hours).

PATIENT OR RESPONSIBLE PARTY SIGNATURE:_____