Beverly Hills Internal Medicine

Distinctly Superior Medical Care.

Please indicate Physician: Farhad Melamed, M.D. Soly Melamed, M.D. Alan G. Silverman, M.D.

PATIENT INFORMATION

LAST NAME	FIRST NAME		DATE
ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE	CELL PHONE	WORK PHONE	
SOCIAL SECURITY #	SEX M F	DATE OF BIRTH	AGE
MARITAL STATUS (CIRCLE ONE) SINGLE MARRIED DOMESTIC PARTNERSHIP DIVORCED WIDOWED			
EMERGENCY CONTACT	PATIENT CONFIDENTIAL EMAIL ADDRESS		
PHONE NUMBER	PHARMACY NAME and ZIP CODE		
RELATIONSHIP TO PATIENT			

INSURANCE INFORMATION

PRIMARY INSURANCE	ID #	RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER
SECONDARY INSURANCE	ID #	RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER

LIFE TIME INSURANCE AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize B.H.I.M. to release for insurance purposes requested information related to my evaluation and treatment.

AUTHORIZATION TO PAY

I hereby authorize B.H.I.M. to bill my insurance company for services rendered, and that I am financially responsible for the charges NOT covered by my insurance plan, including co-payments, deductibles, and co-insurance. In the event that there is an unpaid balance by my insurance, I guarantee to pay the balance promptly. I acknowledge that I am responsible for any fees related to collections agencies or banks fees for returned checks.

SIGNATURE:_____ **DATE:**_____