



RAVIN JAIN, M.D.

Diplomate, American Board of "Ru{ej kv{ "cpf 'P gwtqni { "
Assistant Clinical Professor, UCLA

PATIENT INFORMATION

Last	First	MI	Home No.: ()	-	Cell No.: ()	-
Home Address:		City	State	Zip		
Billing Address:		City	State	Zip	Driver's License No:	
Social Security No.:		-	-	Date of Birth :	/	/
		Age:		Sex: M/F		
Patient's Employer:		Work Address:		Work Phone:		
Spouse's Name:		Spouse's Employer (Name & Address):		Work Phone:		
Emergency Contact Name:		Address:		Phone:		

REFERRED TO THIS OFFICE BY: _____
WHO IS YOUR PRIMARY PHYSICIAN? _____

INSURANCE INFORMATION

Primary Insurance:		
Name: _____	Policy No: _____	Subscriber: _____
Insurance Address: _____		
Secondary Insurance:		
Name: _____	Policy No: _____	Subscriber: _____
Insurance Address: _____		

RESPONSIBLE :		
PARTY	Last	First
Address		Phone
Occupation	Employers Name & Address	Bus. Phone No:

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

METHOD OF PAYMENT: CASH _____ CHECK _____ CREDIT CARD _____

PLEASE READ & SIGN THE FOLLOWING: **RAVIN JAIN, M.D.**
I directly assign all medical/surgical benefits to _____ and understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize the doctor 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.

SIGN HERE _____ **DATE** _____