Multiple Sclerosis Center of California®

Daniel S. Bandari, M.D, Inc.

PATIENT INFORMATION/DEMOGRAPHICS

Referred By: ___________________________Specialty______________________________________

Primary Care Doctor____

Last Name: _____________________ First Name: ____________Date of Birth: _________________

Mailing Address: _______________________________________Do we have permission to email you:_____

Home phone: ____________________Do we have permission to leave a message? :________

Cell phone: ______________________Do we have permission to leave a message? :________ Text:_______

Please Circle one:

Male/Female Single/Married/Divorced/Widowed Employed/Unemployed/Retired/Disabled

Person to contact in case of emergency (Name, Relation & Phone numbers) ***REQUIRED***:

____

Insurance Information:

Primary Insurance Company Name: __________________ID Number: _______________________

Type of Insurance (HMO, PPO, POS, Medicare, None):______________________________________

Name and date of birth of the person who is the insured (Spouse, Father, Mother, Other):

____

Secondary Insurance Company Name: ________________ID Number: ________________________

Type of Insurance (HMO, PPO, POS, Medicare):____

Name and date of birth of the person who is the insured (Spouse, Father, Mother, Other):

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ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I hereby irrevocably assign the insurance benefit payment, both basic and major medical, to which I am entitled directly to the doctor rendering service. I understand that I am financially responsible for the charges not covered by the assignment. A Photostat of this authorization is accepted with the same authority as the original. I hereby authorize the doctor rendering service to release any information required in the course of my examination or treatment.

Insured's Signature***REQUIRED*:** ____ Date: ____________________________

Person who is financially responsible if other than the patient ***REQUIRED***: _____________________Date: _____________________________

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