

Arbi Ohanian, M.D., Inc.

Neurology, Vascular Neurology

PATIENT REGISTRATION RECORD

PATIENT INFORMATION

Last Name	First	M.I.	Home # ()	Date
Street Address		Apt #	Work # ()	ext. Cell # ()
City	State	Zip Code	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /
Social Security # - -	Driver's License #	Referring Physician		Phone # ()

FINANCIALLY RESPONSIBLE PARTY

Last Name	First	M.I.	Relationship <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Spouse <input type="checkbox"/> Legal Guardian	
Street Address		Apt #	Home # ()	Cell # ()
City	State	Zip Code	Work # ()	Ext. #

EMPLOYER INFORMATION

Employer Name	Occupation
Employer Address	Suite # Home # () Cell # ()
City	State Zip Code Work # Ext. #

INSURANCE INFORMATION

Medicare #	Medi-Cal #	Issue Date
Primary Insurance	Subscriber #	Group #
Insurance Mailing Address	Relation to Patient	Subscriber Name & Date of Birth
Secondary Insurance	Subscriber #	Group #
Insurance Mailing Address	Relation to Patient	Subscriber Name & Date of Birth
Worker's Compensation Insurance	Claim #	Adjuster Name Phone # ()
Worker's Compensation Mailing Address	Relation to Patient	Subscriber Name & Date of Birth

EMERGENCY CONTACT INFORMATION

Last Name	First	M.I.	Relationship <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Spouse <input type="checkbox"/> Legal Guardian	
Street Address		Apt #	Home # ()	Cell # ()
City	State	Zip Code	Work #	Ext. #

ASSIGNMENT OF BENEFITS:

I hereby authorize **Arbi Ohanian, M.D., Inc.** to furnish information to insurance carriers concerning this illness. I hereby irrevocably assign to **Arbi Ohanian, M.D., Inc** all payments for medical services rendered and all major medical benefits.

CONSENT FOR TREATMENT:

I hereby authorize my consent to be treated now and in the future at **Arbi Ohanian, M.D., Inc.'s** office.

Signature of Patient/Insured: _____

Date: _____