JAMSHID MADDAHI, MD

PATIENT INTAKE FORM

Appt Date and Time: ____________________

Patient Information				
Name:			Male ☐ Female ☐	
DOB:	Age:	UCLA ID:	SSN:	
Home Phone:		Work Phone:		
Address:		Email:		
City:			State:	Zip:
Emergency Contact:			Phone:	
Referred By:			Phone:	
Reason for Visit:				

Other Physicians	
Primary MD:	Specialty:
Address:	
Phone:	Fax:

Insurance Information: Primary	
Carrier: PPO ☐ HMO ☐ Other ☐	Subscriber/Relationship:
Insurance Phone:	ID:
Plan Code:	Group:
Effective Date:	Deductible: Met ☐ Not Met ☐
Office Visit Co-Pay:	Procedure Co-Insurance:

Insurance Information: Secondary	
Carrier: PPO ☐ HMO ☐ Other ☐	Subscriber/Relationship:
Insurance Phone:	ID:
Plan Code:	Group:
Effective Date:	Deductible: Met ☐ Not Met ☐
Office Visit Co-Pay:	Procedure Co-Insurance:

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS AND I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO JAMSHID MADDAHI, M.D.

I hereby consent to treatment by Dr. Maddahi and any further testing.

I understand that I am responsible to pay any portion of insurance authorized fees that are my responsibility. Should my insurance be not active for any reason I am responsible for all fees submitted. I also understand and agree that any amount on my account over 90 days is subject for a finance charge in the amount of 1% per month (12% annual percentage rate).

____________________ ____

Date Signature of Insured or Authorized Person