

Reed S. Wilson, M.D., Inc.
435 N. Roxbury Dr. Suite #300
Beverly Hills, California 90210
310.859.9170

WELCOME! We are very pleased that you have selected us for your medical care. The law, insurance companies, and our own needs require that we obtain certain information from you, even though you may have already provided them elsewhere, or to us at some time in the past. We appreciate your patience in supplying as complete information as possible. If there is any way in which we can assist you, please do not hesitate to ask.

General Information

Date: _____/_____/_____
Name: _____ Sex: _____ Age: _____
Street Address: _____
City and State Address: _____, _____ Zip: _____
Home Phone Number: _____
Cell Phone Number: _____
Business Phone Number: _____
Email Address: _____@_____
Social Security Number: _____ Date of Birth: ____/____/____

Referred by: _____

Local Friend/Relative (Emergency Contact): _____
Street Address: _____
City and State Address: _____, _____ Zip: _____
Home Phone Number: _____
Cell Phone Number: _____

Employment Information:

Employer Name: _____
Street Address: _____
City and State Address: _____, _____ Zip: _____
Work Phone Number: _____

Private Health Insurance Information

Primary Insurance Carrier: _____
Carrier Street Address: _____
Carrier City and State Address: _____, _____ Zip: _____
Carrier Phone Number: _____
Policy No.: _____ Group No.: _____
Name of Insured: _____
Relation of Insured: _____
Date of Birth: ____/____/____ Social Security Number: _____

Secondary Insurance Carrier: _____
Carrier Street Address: _____
Carrier City and State Address: _____, _____ Zip: _____
Carrier Phone Number: _____
Policy No.: _____ Group No.: _____
Name of Insured: _____
Relation of Insured: _____
Date of Birth: ____/____/____ Social Security Number: _____

It is customary to pay for professional services when rendered. If you cannot settle your account at the time of each office visit, special arrangements must be made with our business office. Patients who carry health insurance should understand that charges for professional services are charged to the patient and not the insurance company. Our office will be happy to bill your insurance carrier for you, should you desire. We must, however, have your portion of the insurance form completed at the time you are seen in order to bill the carrier. Even though an insurance claims is filed, you will receive a statement each month if your account has a balance due. This office cannot accept the final responsibility for collection on insurance or negotiating a settlement on a legal case.

I understand all the above as is evidenced by my signature above

Patient
Signature: _____ Date: _____

Parent or
Guardian: _____ Date: _____

I hereby assign to the doctor whose name appears below all the money to which I am entitled for all medical and/or surgical consultation and/or treatment provided by said doctor. I understand that I am financially responsible to said doctor for all charges not covered by this assignment.

I hereby authorize the doctor whose name appears below to furnish my insurance company all information which the company may request concerning my present illness or injury.

I hereby authorize any doctor, hospital or other medically related facility or institution that has any records and/or x-rays pertaining to me or my health and prior medical history to release such records and/or x-rays to the doctor named below.

Should an attorney be employed or suit commenced to collect payment of my account, I agree to pay such additional sum as the court may adjudge reasonable as attorney's fees and costs in said suit.

A photostatic copy of this authorization shall be as valid as the original

Patient
Signature: _____ Date: _____

Parent or
Guardian: _____ Date: _____

I hereby acknowledge that I am responsible for canceling all appointments to this office 24 hours prior to the time of said appointment. I understand that if I do not cancel my appointment in this time frame that I may be billed for the scheduled visit or test. I further understand that I am financially responsible for the amount billed.

Patient
Signature: _____ Date: _____

Parent or
Guardian: _____ Date: _____