Shaden Sarafzadeh, M.D.
16311 Ventura Blvd. #955
Encino, CA 91436

PATIENT REGISTRATION

Patient Name: _____ Date of Birth:_____

Age:_____ Sex: _____ Social Security Number: _____

Home Address: _____ City: _____

State: _____ Zip:_____ Driver's License No. / State: _____

Home Phone:_____Cell:_____Work:_____

E-mail Address:_____ Employer: _____

Marital Status : □ Single □ Married □ Widowed □ Divorced Spouse: _____

Emergency Contact: _____Relationship: _____Phone: _____

Parent or Guardian (if patient under 18 yo): _____ Phone: _____

How did you hear about us? / Referred by: _____

□ Optometrist □ Physician □ Friend □ Internet _____ □ Insurance Plan

---

INSURANCE INFORMATION

Primary Medical Insurance: _____

ID#: _____ Group: _____

Insured Person's Name: _____ Social Security No: _____

Secondary Medical Insurance: _____

ID#: _____ Group: _____

Insured Person's Name: _____ Social Security No: _____

I hereby authorize an evaluation and treatment by the doctors and staff of Eye Institute of Southern California. I certify that the above insurance information is correct and that if I change insurance plans, I will be liable for all charges incurred due to change in coverage or termination of coverage, and if necessary, applicable court and attorney's fees incurred to collect this amount. I authorize release of any medical information necessary to process this claim and assign payment of medical and surgical claims directly to Eye Institute of Southern California and/or the above named physician. I understand that if I am not eligible with the above insurance or my insurance has changed or terminated, I will assume full responsibility for all charges incurred myself and will pay in full all such charges. I understand that any insurance payments that may be received on my account may not represent full payment for services and that I am responsible for the balance due on my account.

_____ _____

Patient Signature Date