

PATIENT REGISTRATION FORM

Balboa Medical Group

A. LALLOTIS M.D.

BRYAN L. ABRAMOWITZ M.D. INC.

G. LEVINSON M.D.

PATIENT NAME \_\_\_\_\_  
LAST FIRST MIDDLE

DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_/ SEX: M F SSN # \_\_\_\_-\_\_\_\_-\_\_\_\_  
MON DAY YR

EMAIL ADDRESS \_\_\_\_\_

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED SEPARATED

HOME ADDRESS \_\_\_\_\_  
STREET

CITY STATE ZIPCODE

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_

IN CASE OF EMERGENCY CALL \_\_\_\_\_  
NAME PHONE#

**OFFICE POLICY REQUIRES 24 HOUR CANCELLATION NOTICE OF ANY APPOINTMENT OR PATIENT WILL BE SUBJECT TO A "NO SHOW" FEE. THIS FEE IS DETERMINED PER DOCTOR PER INDIVIDUAL PATIENT.**

\_\_\_\_\_  
INITIALS

ASSIGNMENT:

I PERMIT PAYMENT DIRECTLY TO DRS. OFFICE ANY BENEFITS DUE FOR THEIR SERVICES RENDERED.

MEDICAL RECORDS:

AUTHORIZATION IS HEREBY GRANTED FOR RELEASE OF ANY INFORMATION REQUIRED TO PROCESS THIS CLAIM. A COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL.

REGARDLESS OF ANY CLAIM PENDING, YOU WILL RECEIVE PERIODIC STATEMENTS IF YOUR ACCOUNT HAS AN OUTSTANDING BALANCE. WE CANNOT ACCEPT RESPONSIBILITY FOR COLLECTING YOUR INSURANCE CLAIM OR FOR NEGOTIATING A SETTLEMENT ON A DISPUTED CLAIM.

**I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT COVERED BY MY INSURANCE COMPANY.**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_