LAKE HEART SPECIALISTS REGISTRATION FORM
Dr Jajeh, Dr Koch, Dr Jaffe, Dr Nahlawi, Dr Chow, Dr Rojas

Last:	First:	Middle Initial:
Date of Birth:	S.S#	Gender: M / F
Street Address:		
City:	State:	Zip:
Home : ( )	Work: ( )	Cell: ( )
Do we have consent to leave messages at the #'s listed above? YES NO If yes, which ones: Home /Work/ Cell		
Email:		
Height:	Weight:	Marital Status:
Employer:		
Emergency Contact:		
Contact's Phone #:	Relationship to Patient:	

INSURANCE INFORMATION

Primary Insurance:		Is this a HMO?
ID#	Group#	Copay:
Policy Holder's Name:		
Policy Holder's D.O.B:		
Secondary Insurance:		Is this a HMO?
ID#	Group#	Copay:
Policy Holder's Name:		
Policy Holder's D.O.B:		

PRIMARY CARE/ REFERRING PHYSICIANS

Primary Care Physician:	Referring Physician:
Office Location:	Office Location:
Office Phone#	Office Phone #

I hereby authorize **PAYMENT DIRECTLY** to the physician of the medical and/or surgical benefits, in any, otherwise payable to me for his/her services as described, realizing I am responsible **to pay non-covered services and copayments.** I hereby further agree that I shall be responsible for any expenses of Lake Heart Specialists in collecting amounts guaranteed hereby, including all court costs, reasonable attorney's fees and all other collection expenses

I hereby authorize the physicians to release any information acquired in the course of my treatment necessary to process insurance claims.

I have received/read/understood the Notice of Policy Practice YES NO

Patient Signature: Date: