Western Neurological Associates

A MEDICAL CORPORATION

FAWAZ FAISAL, M.D.
Diplomate, American Board of Psychiatry & Neurology
Diplomate, American Board of Clinical Neurophysiology
Diplomate, American Board of Sleep Medicine
Assistant Clinical Professor, UCLA

PATIENT INFORMATION

Last	First	MI	Home No.: ( ) -	Cell No.: ( ) -
Home Address:	City	State	Zip	
Billing Address:	City	State	Zip	Driver's License No:
Social Security No. : - -	Date of Birth : / /	Age:	Sex: M/F	
Patient's Employer:	Work Address:		Work Phone:	
Spouse's Name:	Spouse's Employer (Name & Address):		Work Phone:	
Emergency Contact Name:	Address:		Phone:	

REFERRED TO THIS OFFICE BY:_____

WHO IS YOUR PRIMARY PHYSICIAN?_____

INSURANCE INFORMATION

Primary Insurance:

Name:_____ Policy No: _____ Subscriber:_____

Insurance Address:_____

Secondary Insurance:

Name:_____ Policy No: _____ Subscriber:_____

Insurance Address:_____

RESPONSIBLE PARTY	Last	First	MI
Address		Phone	
Occupation	Employers Name & Address		Bus. Phone No:

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

METHOD OF PAYMENT: CASH_____ CHECK_____ CREDIT CARD_____

PLEASE READ & SIGN THE FOLLOWING: **FAWAZ FAISAL, M.D.**
I directly assign all medical/surgical benefits to _____ and understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

SIGN HERE_____ **DATE**_____