

Ahed Hanna, MD
 2625 West Alameda Ave # 326
 Burbank, CA 91505
 Ph: (818) 566-9991 Fax: (818) 566-9992

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
Address		MI
		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: **AHED HANNA, 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** _____