CEDARS-SINAI MEDICAL GROUP

☐ GARY T. TANOUYE, MD ☐ JEFFREY P. SALBERG, MD ☐ ARDESHIR SOROUSHYARI, MD

Last Name______________________________ First Name ______________________________
(Full Legal Name)

Address ______________________________ Apt.# _______ City ______________________________
(No P.O. Boxes)

State __________ Zip __________ Home Phone ( ) ____________ Cell Phone ( ) ______________

Birthdate ___________ Sex: M F Marital Status: M S W D Referred By:_____________________

Ss# ______________________ Race: __________________ Ethnicity: ______________________

Email Address ________________________________ Preferred Language ____________________

Employer ____

Address ____

City ________________ State _____ Zip ________ Phone ( ) ___________ Ext.______________

Name of Spouse ______________________________ Spouse's Employer ____________________

Address ____

City ________________ State _____ Zip ________ Phone ( ) ___________ Ext.______________

Insurance Information No Insurance ____________ HMO ______________________________

(1) Company Name _________________________ Address ___________________________________
Guarantor ______________________________ Relationship ________________________________
Cert# ____________________________ Group___________________ Mem.__________________

(2) Company Name _________________________ Address ___________________________________
Guarantor ______________________________ Relationship ________________________________
Cert# ____________________________ Group___________________ Mem.__________________

Emergency Contact_________________________________ Relationship ______________________

Address ____

City ______________________ State _______ Zip ____________ Phone ( ) ___________________

Previous Physician ____

Address ____

City ______________________ State _______ Zip ____________ Phone ( ) ___________________

I agree to pay, in a current manner, any charges for professional services.
I understand that although this office bills my insurance, **I am still responsible** for all charges incurred. I do authorize my insurance company to pay benefits directly to this group, and my insurance company may copy my records.

_______________________________ _______________________________________

DATE **SIGNATURE**