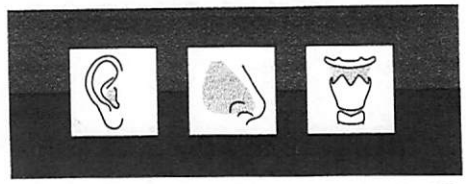


SHAWN S. NASSERI, MD, INC.
DIPLOMATE, AMERICAN BOARD OF OTOLARYNGOLOGY

REGISTRATION FORM

PATIENT INFORMATION: **Today's Date:**_____

LAST NAME: FIRST NAME: MIDDLE: TITLE:

_____ _____ _____ Mr. Mrs. Ms. Dr.

EMAIL ADDRESS : FAMILY MEMBERS WE ALSO CARE FOR:

_____ _____

Social Security Number (req. for billing) Date of Birth: Age: Gender: Marital Status:

_____ _____ _____ M F S M D W P

PRIMARY/RESIDENCE ADDRESS:

Street Address: City: State: ZIP:

_____ _____ _____ _____

Home Phone #: Cell/Pager #: Office #:

_____ _____ _____

EMPLOYER: _____ Occupation: _____

Street Address: City: State: ZIP:

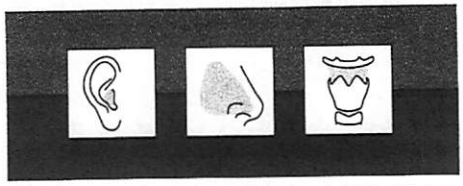
_____ _____ _____ _____

REFERRED TO Dr. Nasseri by: Dr./Mr./Ms./ Mrs._____

PRIMARY CARE DOCTOR:_____ _____
Office #

ALLERGIES: _____

435 N. Bedford Dr., Suite 308 ▪ Beverly Hills, CA 90210
Tel: 310.289.8200 Fax: 310.289.8205 E-Mail NasseriMD@gmail.com



SHAWN S. NASSERI, MD, INC.

BUSINESS MANGEMENT ADDRESS: (If Applicable)

Manager's Name: Phone#:

Contact Person for Billing: Phone #:

Street Address: City: State: ZIP:

INSURANCE INFORMATION:

Please furnish your insurance card(s) in order for us to make a copy. This is for the purpose of courtesy billing your insurance company so you may get reimbursed directly by them for our services. For patients on Medicare, unfortunately we've OPTED OUT of Medicare. NO bills from this office can be submitted to Medicare or any Medicare supplemental.

PERSON RESPONSIBLE FOR BILLING: DOB: SS#:

Address: City: State: ZIP:

Is the responsible person a patient of the office? YES / NO

IN CASE OF EMERGENCY CONTACT:

	NAME:	Phone#:	Relationship to Pt.:	Power of Attorney:
1.				YES / NO
2.				YES / NO

PATIENT CONSENT TO BILLING AND TREATMENT:

I, the above named patient, or his/her legal representative, hereby consent to evaluation and treatment by Dr. Shawn S. Nasseri. I also agree to be responsible to all of the billing generated by the office during my care. I understand that Dr. Nasseri's billing service will be courtesy billing my insurance on my behalf. I understand that Dr. Nasseri is neither a Medicare nor Medical provider, nor is he a provider for my insurance plan. I agree to be legally bound to pay all bills within a 90 day period from their receipt. Independent of other reimbursement, with an accrued interest of 1.5 % per month for bills delinquent over that period of time. I also authorize my insurance company to sent payment to Dr. Nasseri for all care he provided. I also acknowledge that I have been offered a copy of the office Privacy Policy which is posted in the office. R-08/07.

SIGNED: PLEASE PRINT NAME: DATE:

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Tel: 310.289.8200 Fax: 310.289.8205 E-Mail NasseriMD@gmail.com