



Ivan M. Turpin, M.D. & Linda L. Zeineh, M.D.

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PATIENT & INSURANCE INFORMATION (ADULT)

First Name: _____ MI: _____ Last Name: _____ Birthdate: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell #: _____ Work Phone #: _____

Male Female Marital Status: _____ Occupation: _____

Ethnicity: American Indian Asian Hispanic African American Native Hawaiian Caucasian

Language Spoken: _____

Social Security #: _____ Driver License #: _____

Employer (name & address): _____

Name of spouse: _____ Occupation: _____

Employer's name, address & phone #: _____

Social Security #: _____ Birth Date: _____

Who referred you to my office? (If a physician, include address & phone #): _____

Close friend or relative (not living with patient) (name, address & phone #): _____

PRIMARY INSURANCE CARRIER:

Company Name: _____

Claims Billing Address: _____

Subscriber (Insured): _____ Relationship to Patient: _____

Policy Holder (If Group): _____ SS#: _____ DOB: _____

Group or Policy #: _____ Certificate #: _____

SECONDARY INSURANCE CARRIER:

Company Name: _____

Claims Billing Address: _____

Subscriber (Insured): _____ Relationship to Patient: _____

Policy Holder (If Group): _____ SS#: _____ DOB: _____

Group or Policy #: _____ Certificate #: _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize Dr. Turpin and/or Dr. Zeineh to release to my insurance carrier any and all information that might be required in order to evaluate my claim (or potential claim) for insurance benefits pertaining to myself and/or my dependent. I hereby authorize my insurance carrier to pay, and hereby assign directly to Dr. Turpin or Dr. Zeineh any and all benefits otherwise payable to me for their services. I understand that I am financially responsible for all charges incurred over and above those benefits that may be paid directly to Dr. Turpin and/or Dr. Zeineh by my insurance carrier. A copy of this assignment shall be considered as valid as the original.

Authorized signature _____ Date _____

EMAIL AUTHORIZATION

I hereby authorize Dr. Turpin and/or Dr. Zeineh and/or the staff of Dr. Turpin and Dr. Zeineh to use my email address to send me information regarding my medical care, appointments, or to give me information about products or services that may be of interest to me.

Email Address _____

Authorized signature _____ Date _____