Agababian
MEDICAL CLINIC INC.

PATIENT INFORMATION

NAME _____/ _____
(LAST) (FIRST)

BIRTH DATE _____/_____/_____

PATIENTS ADDRESS _____

_____

HOME PHONE _____ CELLPHONE _____

E-MAIL ADDRESS _____

PATIENTS EMPLOYER ADDRESS _____

_____

WORK PHONE _____ OCCUPATION _____

EMERGENCY CONTACT _____

TYPE OF INSURANCE _____

Assignment od Benefits-Financial Agreement

I hereby give authorization for payment of insurance benefits to be made directly to the above named provider for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by my insurance I hereby authorize this health care provider to release all information necessary to secure the payment of benefits.

SIGNATURE _____ DATE _____

6608 SAN FERNANDO RD, GLENDALE, CA 91201 TEL: 818-246-1824 FAX: 818-246-1886 INFO@GORAGABABIAN.COM