LAUREN CIEL SWERDLOFF MD INCORPORATED

1821 WILSHIRE BLVD. SUITE # 220
SANTA MONICA, CA 90403
(310) 829-5189
FAX: (310) 829-5942

Patient's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Patient's Phone: _____Cell/Message Phone:_____

Fax Phone: _____Email:_____

Social Security #: _____ Date of Birth: _____

Employer of Patient: _____ Employer Phone: _____

Employer Address: _____

Responsible Party: _____ SS#: _____

Employer: _____ Address: _____

State: _____ Zip Code: _____ Phone: _____

Name of Insurance Carrier: _____

Insurance Company Address: _____

Policy #: _____ Group #: _____

Name of Insured: _____ Date of Birth: _____

Relationship to Patient: _____

Please present any/all completed insurance forms and insurance cards available to the office.

Any known allergies to medications: _____

EMERGENCY CONTACT: _____ Phone: _____

Relationship: _____ Address: _____

I authorize the release of any medical information necessary to process this claim and request that payment of all benefits be made to the undersigned physician or supplier for services described below. I understand I am financially responsible for non-covered benefits and all deductibles not covered by this authorization. Should the account be referred to an attorney for collection, the undersigned shall pay actual attorney's fees and collection expenses. It is your responsibility to notify us of any changes, including phone number changes.

Signed (Insured or Authorized Person): _____ Date: _____
Name of person who referred you to this doctor: _____