Vanessa Shana Rothholtz, M.D., Inc.

2080 Century Park East #1609, Los Angeles, CA 90067

Patient Name: _____ ***Sex:*** _____

Address: _____ ***Marital Status:*** _____

City: _____ ***State:*** _____ ***Zip Code:*** _____

Date of Birth: ____/____/____ ***Primary Language:*** _____

Race: _____ ***Ethnicity:*** _____

Social Security No: _____ ***Drivers License:*** _____

Mark your primary number with an asterisk (*) ***( ) Cell Phone:*** _____

( ) Work Phone: _____ ***( ) Home:*** _____

May we leave a detailed message with results on your primary voicemail? ( ) Yes or ( ) No

Email Address: _____ ***Pharmacy Name/Number:*** _____

Occupation: _____ ***Employer:*** _____

Insurance Company: _____ ***I.D. No. / Medicare No:*** _____

Insured Name: _____ ***Insured Date of Birth:*** ___/____/____

Insured Social Security Number: _____ ***Relationship to insured:*** _____

Whom shall we thank for referring you? _____

Personal Physician: _____ ***Telephone:*** _____

May we send your physician a report of our findings: ( ) Yes or ( )No

Emergency Contact: _____ ***Telephone:*** _____

Relationship to Emergency Contact: _____

I authorize the release of medical information to my insurance company ( ) Yes ( ) No

BILLING POLICY: PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED, unless your physician is contracted with your insurance carrier (including Medicare). The insurance company is hereby authorized to pay all benefits directly to my attending physician. If special arrangements for payment are needed, they must be made prior to services; please ask for the office manager. We do not accept MediCal or legal liens.

I have read the above policy and understand my financial responsibility.

Date: _____ ***Signature:*** _____