



Western Neurological Associates

A MEDICAL CORPORATION

FAWAZ FAISAL, MD

Diplomate, American Board of Neurology & Psychiatry
Diplomate, American Board of Clinical Neurophysiology
Diplomate, American Board of Sleep Medicine
Assistant Clinical Professor, UCLA

RAVIN JAIN, MD

Diplomate, American Board of
Psychiatry and Neurology
Assistant Clinical Professor, UCLA

PATIENT INFORMATION

Last	First	MI	Home No.: ()	-	Cell No.: ()	-
Home Address:		City	State	Zip		
Billing Address:		City	State	Zip	Driver's License No:	
Social Security No. :		-	-	Date of Birth :	/	/
		Age:		Sex: M/F		
Patient's Employer:		Work Address:		Work Phone:		
Spouse's Name:		Spouse's Employer (Name & Address):		Work Phone:		
Emergency Contact Name:		Address:		Phone:		

REFERRED TO THIS OFFICE BY: _____
WHO IS YOUR PRIMARY PHYSICIAN? _____

INSURANCE INFORMATION

Primary Insurance:		
Name: _____	Policy No: _____	Subscriber: _____
Insurance Address: _____		
Secondary Insurance:		
Name: _____	Policy No: _____	Subscriber: _____
Insurance Address: _____		

RESPONSIBLE :		
PARTY	Last	First
Address		Phone
Occupation	Employers Name & Address	Bus. Phone No:

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

METHOD OF PAYMENT: CASH _____ CHECK _____ CREDIT CARD _____

PLEASE READ & SIGN THE FOLLOWING: **FAWAZ FAISAL, M.D.** **RAVIN JAIN, M.D.**
I directly assign all medical/surgical benefits to _____ and understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

SIGN HERE _____ **DATE** _____