GREG J. NELSON, M.D.
HELEN H. NAM, M.D
15243 Vanowen Street, STE 212
Van Nuys, CA 91405
(818-785-8707)

FULL NAME: ______________________________ F___ M ___ REFERRED BY : ______________

FULL ADDRESS: ______________________________ CITY______________ ZIP CODE_________

CELL PHONE#____________________HOME PHONE#_______________ BIRTH DATE: ________

SOC. SEC. #: (only for the 3 following insurance) _______________________

MEDICARE: _______________ TRICARE:________________ MOTION PICTURE:_____________

EMPLOYER NAME: _________________________________ BUSINESS #:__________________

BUSINESS ADDRESS:____

EMERGENCY CONTACT: _________ TELEPHONE #:_____________________________________

INSURANCE INFORMATION

INSURANCE NAME & ADDRESS:____

I.D. AND GROUP #:____

PRIMARY INSURED: ID OR SS#____

DATE OF BIRTH: ________________ CO-PAY/DEDUCTIBLE ______________________________

RELATIONSHIP:____

SECONDARY INSURANCE:____

AUTHORIZATION OF PAYMENT TO PHYSICIAN

I HEREBY AUTHORIZE THE ABOVE MENTIONED INSURANCE COMPANY TO PAY BY CHECK MADE OUT TO ME AND MAILED DIRECTLY TO:

GREG J. NELSON, M.D.
P.O. BOX 55637
SHERMAN OAKS, CA 91413

ALL MEDICAL BENEFITS INCLUDING MEDICARE AND OTHER GOVERNMENT SPONSORED PROGRAMS, PRIVATE INSURANCE AND OTHER HEALTH PLANS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION TO ENSURE PAYMENT.

PATIENT SIGNATURE: ______________________________ DATE:______________________