Cedars-Sinai Medical Office Towers
8631 W. 3rd Street, Suite 825E, Los Angeles, CA 90048 ◆ Phone: 310.652.5021
www.JoelFeinsteinMD.com

PATIENT INFORMATION FOR MEDICAL RECORDS (Please Print)

NAME_____Male_____Female_____
Last *First* *MI*

Social Security #_____Drivers License _____ Birthdate ____/_____/____ Age____

ADDRESS_____City_____State_____Zip_____

PHONE: Home_____Cell_____Work_____

*EMAIL:_____STATUS: ❑Married ❑Single ❑Widow/er ❑Minor

EMPLOYED BY _____OCCUPATION_____

WORK ADDRESS _____

SPOUSE/PARENT/OTHER:_____ NAME _____

OCCUPATION_____ADDRESS_____*EMAIL_____

PHONE: Home_____Cell_____Work_____

WHO REFERRED YOU TO THIS OFFICE?_____

MEDICAL INSURANCE INFORMATION

NAME OF INSURANCE CO._____ ADDRESS _____

POLICY #_____ GROUP NAME/#_____

Payment made by: ❑Cash ❑Check ❑Credit Card ❑Insurance ❑Medicare

IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT, PLEASE COMPLETE:

NAME_____

ADDRESS_____*EMAIL:_____

RELATIONSHIP TO THE PATIENT_____Soc. Sec. #_____

PHONE: Home_____Cell_____Work_____

EMPLOYED BY _____ ADDRESS_____

PLEASE SIGN AND RETURN TO THE FRONT DESK

The undersigned has insurance coverage with _____and assign directly to

JOEL D. FEINSTEIN M.D. all surgical and /or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Date_____Signed_____

NOTE: Pease notify us if any of the above information changes during the course of your treatment.

**This office will not share your email address with another party or use your email for purposes other than office information directed for your use only.*