

PATIENT INFORMATION SHEET

Irina Jasper M.D.
960 E. Green St., Suite 286
Pasadena, Ca 91106
Tel: (626) 356-0340 Fax: (626) 356-0390

CASH _____ GRP INS _____ MEDI-CARE _____ MEDI-CARE/MEDI-CAL _____ OTHER _____

PLEASE PRINT CLEARLY

In order for us to properly process your payment information to insurance companies, and to make things easier for YOU, we appreciate your filling in the form IN FULL. This will take a little of your time now, but will make everything easier in the future.

Thank You- Your Doctor and her Staff

DATE _____ REFERRING DOCTOR _____

NAME _____ SS# _____

MARITAL STATUS _____ SEX FEMALE or MALE

ADDRESS _____ DATE OF BIRTH _____

CITY _____ ZIP _____ HOME PHONE () _____

PLACE OF EMPLOYMENT _____ OCCUPATION _____

ADDRESS _____ WORK PHONE () _____

CITY _____ ZIP _____

SPOUSE'S/PARTNER'S NAME _____ DATE OF BIRTH _____

SPOUSE'S PLACE OF EMPLOYMENT _____ OCCUPATION _____

SPOUSE'S SS# _____ WORK PHONE () _____

PERSON TO NOTIFY IN CASE OF EMERGENCY _____

HOME PHONE () _____ WORK PHONE () _____

INSURANCE INFORMATION:

NAME OF COMPANY _____ INSURED NAME _____

ADDRESS _____ TELEPHONE () _____

CITY _____ ZIP _____

GROUP # _____ POLICY OR CERTIFICATE # _____

MEDICARE # _____

SECOND INSURANCE _____ INSURED NAME _____

ADDRESS _____ TELEPHONE () _____

CITY _____ ZIP _____

GROUP # _____ POLICY OR CERTIFICATE # _____

Authorization and Assignment

For commercial insurance or Non-insured:

I authorize Irina Jasper, M.D. to provide care and treatment and to release information that may be requested by insurance companies to whom I have submitted a claim, and hereby request _____ insurance company, to pay Irina Jasper, M.D., all benefits accruing to me under my Surgical, Hospitalization, and Medical Plan. I hereby certify that I am eligible with the insurance plan mentioned above and that I have chosen Irina Jasper, M.D. as my attending physician.

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE TO THE PHYSICIAN FOR ALL CHARGES NOT COVERD BY THE ASSIGNMENT. _____
(INITIALS)

I UNDERSTAND THAT IF I AM NOT ELEGIBLE, OR DO NOT HAVE INSURANCE, I AM RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED. _____
(INITIALS)

Signature of Patient Date: ____/____/____

For Medicare Recipients:

I request that payment under the Medicare Medical Insurance Program be made to Irina Jasper, M.D. on any bills for services furnished me by the above physician. I authorize the release of medical information to the Health Care Financing, Administration and its agents, if needed, in order to determine benefits payable and to process my insurance claims.

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE TO THE PHYSICIAN FOR ALL CHARGES NOT COVERD BY THE ASSIGNMENT. _____
(INITIALS)

I UNDERSTAND THAT IF I AM NOT ELEGIBLE, OR DO NOT HAVE INSURANCE, I AM RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED. _____
(INITIALS)

Beneficiary Name _____ Medicare Number _____
(AS IT APPEARS ON THE CARD)

Signature of Patient Date: ____/____/____