Patient Information

8733 Beverly Blvd., Ste 408, West Hollywood, CA 90046 t: 310-295-2255 f: 310-657-4950

Name: _____DOB: _____Gender: M F
Marital Status: S M D W

Address: _____City: _____ State: _____ Zip Code: _____

Home Tel: _____Mobile: _____Pharmacy: _____

SSN: _____-_____-_____ Email:_____ By providing this you authorize email communication from our office.

Employer: _____ Tel No.: _____

Medical Insurance: _____

_____

Address: _____City: _____State: _____ Zip Code: _____
Emergency Contact:
Name: _____ Tel: _____ Relationship: _____
Allergies:

_____

_____

Date of Injury: _____ Claim No.:_____

*Note: Your insurance is a contract between you, your employer and the insurance company. We are NOT a party to that contract.
I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. There will be a 1.5% interest charge per month and a 30% collection fee for overdue accounts. I have read all the information and have completed the above answers. I certify this information is true and correct to the best of my knowledge.

Dr. Aggarwal may refer you o receive services from Kansal, Inc., a professional medical corporation in which Dr. Aggarwal has an ownership interest. Dr. Aggarwal may refer you to Kansal based in his sound medical judgment and his first-hand knowledge of the excellent healthcare professionals affiliated with Kansal. It is important for you to know that Dr. Aggarwal will not receive anything in return for referring you tot Kansal, and you are free to choose any other physician or medical corporation to meet your health care needs.

Sign_____ Date_____