SHARAM DANESHGAR, M.D
Gastroenterology

Name _____ **Date of Birth** _____ **Age** ____

Address _____
Street City State Zip Code

Sex: Male Female **Marital Status:** Single Married Widow

Home Phone _____ **Cell Phone** _____ **Work Phone** _____

Employer _____ **Occupation** _____

Address _____
Street City State Zip Code

Spouse/Parent _____

Spouse/Parent Date of Birth _____

Employer _____ **Work Phone** _____

Name of Person to be billed _____

Referring Doctor _____

Please read and sign below:

I authorize payment of insurance benefits to be made directly to Dr. Sharam Daneshgar for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I authorize Dr. Sharam Daneshgar to release all information necessary to ensure the payment benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

_____ _____
Signature Date

****

FOR OFFICE USE ONLY

Ins. Co. _____ _____
Address _____ _____
_____ _____
Phone # _____ _____
ID # _____ _____
GR # _____ _____
Eff. Dt. _____ _____
Ded. Amt. _____ _____
Payable _____ _____
Co Pay _____