Dr. Ali Tehrani
18064 Wika Road, Suite 103, Apple Valley, CA 92307
Phone: (760) 240-2444 · Fax: (760) 240-5554
www.tehraniplasticsurgery.com

PATIENT REGISTRATION FORM

Today's Date:	Primary Care Physician:

PATIENT INFORMATION

(Please Give Your Drivers License or Photo I.D. To The Receptionist)

☐ Mrs. ☐ Ms. ☐ Mr. ☐ Miss	Patient's Last Name:	First:	Middle:	Marital Status (Circle One)
				Single / Married / Divorce / Widow

Social Security #:	Drivers License #:	Birth Date:	Age:	Sex:	E-mail Address:
		/ /		☐ F ☐ M	

Address:	City:	Zip Code:

Cell Phone #:	Leave A Message:	Home Phone #:	Leave A Message:	Work Phone #:	Leave A Message:
( )	☐ Yes ☐ No	( )	☐ Yes ☐ No	( )	☐ Yes ☐ No

Occupation:	Employer:

Referred By: ☐ Doctor ☐ Family Member ☐ Friend ☐ Current Patient ☐ Magazine ☐ Internet
Please list referral's name _____ ☐ Other
_____

INSURANCE INFORMATION

(Please Give Your Insurance Card To The Receptionist)

Primary Insurance

Subscriber's Name	Subscriber's S.S. #:	Birth Date:	Policy #:	Group #:

Plan Name:	Address:	Phone #:	Effective Date:
		( )	

Relationship To Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other
_____

Secondary Insurance

Subscriber's Name	Subscriber's S.S. #:	Birth Date:	Policy #:	Group #:

Plan Name:	Address:	Phone #:	Effective Date:
		( )	

Relationship To Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other
_____

IN CASE OF EMERGENCY

Dr. Ali Tehrani
18064 Wika Road, Suite 103, Apple Valley, CA 92307
Phone: (760) 240-2444 · Fax: (760) 240-5554
www.tehraniplasticsurgery.com

Name Of Relative Or Friend Not Living With You:	Relationship To Patient:	Home Phone #:	Work Phone #:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Dr. Ali Tehrani. I authorize the practice to release to the Health Care Financing Administration (HCFA/CMMS), my insurance carrier and/or its agents appropriate information needed to determine there benefits payable for related services, in accordance with HIPPA guidelines. I am financially responsible for appropriate deductibles, co-payments, and non-covered items. If this account has to be turned over to an attorney due to delinquency or non-payment, I will be responsible for all cost of collections including the court costs and reasonable attorney fees.

____
Patient/Guardian Signature   Date