

TODD H. LANMAN, M.D.
120 S. SPALDING DRIVE STE. 400
BEVERLY HILLS, CA 90212
TEL: 310-385-7766 FAX: 310-385-9007

NAME: _____ AGE: _____ DATE OF BIRTH: _____

HOME ADDRESS: _____ CITY: _____ ZIP CODE: _____

HOME#: () _____ BUSINESS: () _____

CELL: () _____ FAX: () _____

S.S. #: _____ DRIVER'S LICENSE: _____

MALE: _____ FEMALE: _____ MARRIED: _____ SINGLE: _____ WIDOWED: _____ DIVORCED: _____ SEPARATED: _____

OCCUPATION OF PATIENT: _____ EMPLOYER: _____

BUSINESS ADDRESS: _____ CITY: _____ ZIP CODE: _____

NAME OF SPOUSE: _____ OCCUPATION OF SPOUSE: _____

EMPLOYER: _____ BUSINESS TELEPHONE: _____

ARE YOU SEEING DR.LANMAN BECAUSE OF A JOB RELATED INJURY? YES: _____ NO: _____

NAME OF INTERNIST OR PRIMARY CARE PHYSICIAN: _____ TEL: _____

WHO REFERRED YOU TO DR.LANMAN? _____ TEL: _____

PLEASE FURNISH THE NAME OF A RELATIVE OR FRIEND WE CAN CONTACT IN AN EMERGENCY (NOT YOUR SPOUSE)

NAME: _____ RELATIONSHIP: _____

HOME TEL: _____ BUSINESS TEL: _____

ADDRESS: _____

DO YOU HAVE MEDICAL INSURANCE? YES: _____ NO: _____ INSURED I.D.#: _____

NAME OF SUBSCRIBER: _____ INSURED GROUP#: _____

NAME OF INSURANCE: _____ TEL: _____

INSURANCE MAILING ADDRESS: _____

PLEASE READ CAREFULLY:

I HEREBY AUTHORIZE MY INSURANCE CARRIER TO RELEASE INFORMATION REGARDING MEDICAL BENEFITS PAYABLE UNDER MY POLICY, AND TO PAY MEDICAL BENEFITS DIRECTLY TO TODD H.LANMAN, M.D., A MEDICAL CORPORATION. I HEREBY AUTHORIZE ANY MEDICAL CARE PROVIDER TO RELEASE ANY MEDICAL RECORDS AND REPORTS CONCERNING MY ILLNESS AND/OR TREATMENT DIRECTLY TO TODD H. LANMAN, M.D. A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL.

DR.LANMAN IS PLEASED TO BE AFFILIATED WITH S&B SURGERY CENTER, LOCATED IN BEVERLY HILLS, CALIFORNIA. WHILE DR.LANMAN AT TIMES BELIEVES IT IS IN HIS PATIENTS BEST INTEREST TO REFER THEM TO THIS SURGERY CENTER, PATIENTS SHOULD BE AWARE THAT THEY ARE FREE TO CHOOSE ANY ORGANIZATION OR SURGICAL CENTER TO PROVIDE THE SERVICES WHICH DR. LANMAN RECOMMENDS.

SIGNATURE OF PATIENT OR GUARDIAN

DATE