

LAWRENCE L. LIN, MD
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DATE: _____ - _____ 200__ Age: _____

Patient's Information

Last Name _____
First & Initial _____
Home Address: _____
City _____ ST _____ ZIP _____
Home Phone() _____
Cell Phone () _____
Date Of Birth: M _____ D _____ Y _____
Social Security # _____ -- _____ -- _____
Marital status (please circle one):
Married Single Separated Divorced Widow Partnered

Your Employer

Name _____
Address _____
City _____ ST _____ ZIP _____
Phone() _____ Ext _____
Type Of Work _____

Your Insurance Company's

Name _____
Address _____
City _____ ST _____ ZIP _____
Phone() _____ Ext _____
Subscriber # _____
Group # _____ Copay \$ _____

Primary Physician _____

Phone() _____ FAX() _____

Referring Physician _____

Phone() _____ FAX() _____

Other Referring _____

May we thank them for the referral? Yes No

ALLERGIES: _____

Guarantor's Information (Spouse or _____)

Last Name _____
First and Initial _____
Home Address: _____
City _____ ST _____ ZIP _____
Home Phone () _____
Cell Phone () _____
Date Of Birth: M _____ D _____ Y _____
Social Security # _____ -- _____ -- _____

Guarantor's Employer

Name _____
Address _____
City _____ ST _____ ZIP _____
Phone() _____ Ext _____
Type Of Work _____

Guarantor's Insurance Company's

Name _____
Address _____
City _____ ST _____ ZIP _____
Phone() _____ Ext _____
Subscriber # _____
Group # _____ Copay \$ _____

EMERGENCY Name: _____

CONTACT Phone: () _____

Relationship: _____

PLEASE READ THE FOLLOWING IMPORTANT INFORMATION CAREFULLY

LAWRENCE L. LIN M.D. agrees to provide professional services by the physician and its employees to each patient and reserves the right to select the physician to perform the services required when he is not present to perform the services.

I hereby authorize LAWRENCE L. LIN M.D. to furnish information to insurance carriers concerning my diagnosis and treatment and I hereby assign to the physician all payments for services rendered to myself or my dependents. I understand that all professional services rendered are charged to the patient. As a courtesy, necessary forms will be completed to expedite insurance payments. **I understand that I am responsible for any amount not covered by insurance.**

Lawrence Lin, MD is a contracted provider for Medicare, Anthem Blue Cross, Blue Shield of CA, and most other major insurance companies. Due to the number of different insurance companies and their own numerous policies, we cannot be responsible to know the terms of your individual policy, even if we are a provider. **It is your responsibility as the patient to know your insurance policy's requirements** for prior authorization for office visits, X-rays, laboratory, and the amount of your deductible and co-payments. Furthermore, it is also necessary for you to know which laboratory, X-ray facility, and hospital you are required by your insurance to use for any necessary test and procedures. **Your condition may require further in-office procedures, such as Multichannel Urodynamics ("Bladder Study") or a Cystoscopy, as part of your medical workup. Please check with your insurance company regarding their specific requirements and coverage for these services.**

Please ask our office if you have any questions regarding the above. By signing below you acknowledge that you have read and understood the above.

The best medical service is based on a friendly mutual understanding between doctor and patient.

Patient or Authorized Signature _____ Witness _____ Date _____