



SINU-CLEAR, INC.

HARVEY D. PALEY, M.D. ~ 9301 WILSHIRE BOULEVARD ~ SUITE 404 ~ BEVERLY HILLS, CA 90210

PATIENT INFORMATION

Date _____

Name _____ Date of Birth _____ M F

Address _____ Apt. No. _____ Phone () _____

City _____ State _____ Zip Code _____

Marital Status: M S D W Sep Social Security No. _____ Cell Phone: _____

Patient's Occupation: _____ Employer: _____

Business Address: _____ Business Phone () _____

Referred By: _____

Spouse or Nearest Relative: _____ Relationship: _____

Address _____ Phone () _____

Occupation _____ Employer _____

Business Address _____ Business Phone () _____

Emergency Contact _____ Relationship _____

Address _____ Phone () _____

Primary Physician: _____ Phone () _____

INSURANCE INFORMATION

Insurance Company _____

Insurance Co. Address _____

Subscriber No. _____ Social Security No. / Medicare No. _____

Group or Policy No. _____ Membership or Certificate No. _____

Consent to Treat: I, the undersigned, hereby consent to the administration and performance of all diagnostic procedures and treatments which, in the judgment of my physician, may be considered necessary or advisable.

Assignment and Release: I, the undersigned, hereby authorize my insurance company to assign directly to Dr. Harvey Paley all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Harvey Paley to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. A copy of this authorization is as valid as the original. * Insurance will be billed as a courtesy. All appropriate co-payments and deductibles are due at the time of service.

Patient Signature X _____ Date _____