Thomas Susko M.D., Inc.
2021 Santa Monica Blvd #200e
Santa Monica, CA 90404
Phone: (310) 829-5557
Fax: (310) 829-5554

Good Medicine Takes Time

Patient Registration

Date:____/____/____

New ☐ Add ☐ Change ☐

Personal Information

Patient Name (Last, First, MI)		Address	
Social Security #	DL#	City, State	Zip Code
Date of birth	State Exp	Home Phone	Work Phone
Primary Language	Sex M ☐ F ☐	Cell Phone	E-Mail Address

Marital Status SINGLE ☐ MARRIED ☐ OTHER ☐

Referred by First Name Last Name

Primary Care Physician First Name Last Name

Employment Information

Employment Status

Full-Time ☐ Part-Time ☐ Self-Employed ☐ Not Employed ☐

Retired ☐ (Date Retired) _____ Student ☐

Name of Employer / Union / Guild	Occupation
Employer Address	Employer City, State, ZIP

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Guarantor Information

Name of Person who is Financially Responsible for the Patient	Relation to Patient

Employer	Social Security Number	Date of Birth

Primary Insurance Information

Primary Insurance	PPO ☐ POS ☐ HMO ☐	Subscriber ID#	Phone Number

Member Effective Date	Relationship to Subscriber	Group#	Group Name

If the insurance is Medicare, have you assigned your benefits to an HMO? YES ☐ NO ☐	(If Yes) Medical Group Name

Secondary Insurance Information

Secondary Insurance	PPO ☐ POS ☐ HMO ☐	Subscriber ID#	Phone Number

Member Effective Date	Relationship to Subscriber	Group#	Group Name

If the insurance is Medicare, have you assigned your benefits to an HMO? YES ☐ NO ☐	(If Yes) Medical Group Name

PLEASE SIGN SO WE MAY HAVE YOUR INSURANCE AUTHORIZATION ON FILE

I authorize any holder of medical or other information about me to release to the above insurance company(s) any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment.

SIGNATURE:_____ DATE: _____

Please provide your insurance card(s) and driver's license to the receptionist along with this form.