Watson Wellness

Cynthia Watson, M.D.

3201 Wilshire Blvd. Suite #211
Santa Monica, CA 90403
Phn: 310-315-9101 Fax: 310-829-9860

*Last Name:	*First Name:	MI:
SS#:	*DOB:	*Sex: M F	Full time student? Y N
Referring Physician:		
*Address 1:	Address 2:	
*City:	*State:	*Zip:
*Home phone:	Work Phone:	Cell Phone:

Please leave a phone number where we can leave a confidential message:

_____

Please provide us with your E-Mail address:

_____

Referred by:

_____

Guarantor Information: (skip this section if same as patient)

Last Name:	First Name:	MI:
SS#:	DOB:	Sex: M F
Address 1:	Address 2:	
City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:

Primary Insurance Information: (enter subscriber information)

Name of Insurance:	Medical Group or IPA:	
*ID#:	Group/Policy #:	Relationship to Insured:
*Last Name:	*First Name:	MI:
SS#:	*DOB:	Sex: M F	*Phone #:

*Address 1:	Address 2:	
*City:	*State:	*Zip:

Secondary Insurance Information: (enter subscriber information)

Name of Insurance:		Medical Group or IPA:	
*ID#:	Group/Policy #:	Relationship to Insured:	
*Last Name:		*First Name:	MI:
SS#:	*DOB:	Sex: M F	*Phone #:
*Address 1:		Address 2:	
*City:	*State:	*Zip:	

Nearest Relative/ Emergency Contact Information	Relationship
Name	Cell/Home Phone Number
Address	Business Phone

Please remember that prescriptions and phone calls can take up to 24 hours before being returned. (Emergencies however are PRIORITIES.)

Watson Medical Inc.

Dr. Watson is a fee for service provider. Each patient is responsible for any and all fees incurred, including but not limited to doctors' visit, laboratory and intravenous procedures. Dr Sudarsky takes Blue Cross, Blue Shield **PPO ONLY** and Medicare. In the event we do take your insurance, (Medicare, Blue Cross, Blue Shield etc.) I authorize Watson Medical Inc., to release to my insurance company, any insurance information required to process a claim.

Assignment: I hereby assign my insurance benefits to be paid directly to the undersigned physician. I am financially responsible for any uncovered services:

As the responsible party for my health care, I have read and agree to all of the above.

Signature_____

Date_____