

**MARILYN RAND, Ph.D., M.F.C.C.**  
**19634 VENTURA BOULEVARD SUITE 325**  
**TARZANA, CALIFORNIA 91356**  
**TELEPHONE 818 – 774 – 0660**

**PATIENT INFORMATION**

**PERSONAL**

Patient Name \_\_\_\_\_ Date Of Birth \_\_\_\_\_  
Home Address \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
Marital Status \_\_\_\_\_ Spouse Name \_\_\_\_\_ SSN \_\_\_\_\_

**MEDICAL**

Patient's Employer \_\_\_\_\_ Phone No. \_\_\_\_\_  
Responsible Party (If Patient Is Child) \_\_\_\_\_  
Medical Insurance \_\_\_\_\_ Phone No. \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Certificate # \_\_\_\_\_ Group # \_\_\_\_\_  
Secondary Medical Insurance \_\_\_\_\_ Phone No. \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Certificate # \_\_\_\_\_ Group # \_\_\_\_\_

**I hereby assign all medical benefits to which I am entitled, including Private Insurance and any other Health Plans to Marilyn Rand, Ph.D., M.F.C.C. This assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date