

# SYNAPSE

MEDICAL GROUP

**EDWIN HARONIAN, MD**  
Orthopedic and Spine Surgeon

**ALEX GHASEM, MD**  
Orthopedic and Spine Surgeon

**LEVI HARRISON, MD**  
Hand Surgery

**ALLEN MASSIHI, DPM**  
Podiatrist

**WALTER H. BURNHAM, MD**  
Spine Surgery

**JONATHAN KOHAN, MD**  
Anesthesiologist Pain Management

**ARASH YAGHOUBIAN, MD**  
Orthopedic and Spine Surgeon

**BERKAY UNAL, MD**  
Orthopedic Surgery & Joint Replacement

**HEATH HINZE, PSY. D**  
Clinical Psychologist

**JONATHAN BERKOWITZ, MD**  
Sports Orthopedic Surgeon

**SHERRY LEONI, DC**  
Chiropractor

**JONATHAN NASSOS, MD**  
Orthopedic Surgeon & Sports Medicine

**RONALD E. GLOUSMAN, MD**  
Sports Medicine & Arthroscopic Surgery

**NICOLE RECORD, DO**  
Spine Surgery

Tel: 818-788-2400 Ext. 103 Direct Line: 818-616-1623 Direct Fax: 818-788-2333 - Email: [NewPatient@synapsedoctor.com](mailto:NewPatient@synapsedoctor.com)

Scheduling Department/Locations:  Sherman Oaks  Pomona  Los Angeles

WC 2nd Treat  WC PTP  QME  AME  IME  CONSULT  PRIVATE

Post Termination Claim?  Yes  No We accept post termination claims only with explanation.

PATIENT'S NAME: \_\_\_\_\_

TELEPHONE NO: (\_\_\_\_) \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

**REFERRING SOURCE/PROVIDER:**

GROUPS NAME: \_\_\_\_\_ PRIMARY TREATING PHYSICIAN \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE NO: (\_\_\_\_) \_\_\_\_\_ EMAIL: \_\_\_\_\_

INSURANCE: \_\_\_\_\_ DOI: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PRIMARY TREATING PHYSICIAN \_\_\_\_\_

TELEPHONE NO: (\_\_\_\_) \_\_\_\_\_ FAX NO: (\_\_\_\_) \_\_\_\_\_

CLAIM #: \_\_\_\_\_ WCAB#: \_\_\_\_\_

ADJUSTER NAME: \_\_\_\_\_ TELEPHONE NO: \_\_\_\_\_

BODY PARTS TO BE TREATED: \_\_\_\_\_

APPLICANT ATTORNEY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE NO: (\_\_\_\_) \_\_\_\_\_ FAX NO: (\_\_\_\_) \_\_\_\_\_

ADJUSTER NAME: \_\_\_\_\_ TELEPHONE NO: \_\_\_\_\_

DEFENSE ATTORNEY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE NO: \_\_\_\_\_ FAX NO: (\_\_\_\_) \_\_\_\_\_

CONTACT NAME: \_\_\_\_\_ EMAIL: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE NO: (\_\_\_\_) \_\_\_\_\_ FAX NO: (\_\_\_\_) \_\_\_\_\_

This completed document along with all applicable medical records can be sent to [NewPatient@synapsedoctor.com](mailto:NewPatient@synapsedoctor.com)

**No children allowed in the office no exception**