Please Give Photo ID , Insurance Card (s) and Referral Slips To Office Staff to Copy

PLEASE PRINT CLEARLY AND ANSWER ALL INFORMATION

Patients Name:_____ _____
LAST FIRST MIDDLE INTL DATE OF BIRTH

Address: _____

Phone # _____Work/ Cell #: _____ Social Security#_____

SEX: MALE / FEMALE **Medical Insurance Information**

PRIMARY INSURANCE:

Name of Person Insured:_____ Insured's Date of Birth_____

Relationship to Patient: Self Spouse Parent Child Other (***Please Circle***)

Primary Insurance:_____ Policy / Subscriber #_____

Group#_____ Effective Date of Converge:_____ COPAY $_____

SECONDARY INSURANCE:

Name of Person Insured:_____ Insured's Date of Birth_____

Relationship to Patient: Self Spouse Parent Child Other (***Please Circle***)

Primary Insurance:_____ Policy / Subscriber #_____
Group#_____ Effective Date of Converge:_____ COPAY $_____

PHARMACY INFORMATION

Pharmacy: _____ _____ _____
NAME Pharmacy Address Pharmacy Phone

Pharmacy: _____ _____ _____
NAME Pharmacy Address Pharmacy Phone

Please Circle *Yes or No* for all questions that apply

Is this a worker's compensation injury or illness?	**YES**	**NO**
Is this related to a car accident?	**YES**	**NO**
Have you had similar symptoms in the past?	**YES**	**NO**
Where you recently hospitalized?	**YES**	**NO**

EMERGENCY CONTACT: _____ _____
NAME **PHONE NUMBER**

REFERING PHYSICIAN: _____ _____
Physicians Name **Physicians Office Number**

PLEASE READ BEFORE SIGNING:
I hereby authorize, LALITHA ANANTH MD FACP to furnish information to my insurance carrier(s) concerning my illness and I herby assign to the doctor all payments for medical services rendered. Should my insurance not pay the charges incurred, I agree that I am responsible for all charges and balances not paid by my insurance. I agree that a photo static copy of this authorization shall be considered as effective as the original.