

PATIENT INFORMATION FORM

Please circle one of the following:

I AM A PATIENT OF:

Dr. Mathur

Dr. Singh

GENERAL INFORMATION:

Patient's Name: _____
(Last) (First) (Middle Initial)

Sex: M F

Current Address: _____
(Street) (City) (Zip Code)

Patient's Date of Birth: ____/____/____ Patient's Social Security Number: ____/____/____

Home Phone # () ____ - ____ Cell Phone # () ____ - ____ Work Phone # () ____ - ____

Emergency Contact Name and Phone Number: _____

Email Address: _____

MOTHER'S NAME: _____
PHONE # () ____ - ____

FATHER'S NAME: _____
PHONE # () ____ - ____

EMPLOYERS NAME AND ADDRESS: _____

NATIONALITY: _____

RELIGION: _____

LANGUAGES SPOKEN: _____

PRIMARY INSURANCE

Name of Insurance: _____

Patient's ID # _____ Suffix _____

Group Number: _____

Co-pay Amount _____ Deductible Amount _____

Cardholder's Name: _____

Cardholder's Social Security # _____

Cardholder's Date of Birth: _____

Relationship to Patient: _____

SECONDARY INSURANCE

Name of Insurance: _____

Patient's ID # _____ Suffix _____

Group Number: _____

Co-pay Amount _____ Deductible Amount _____

PHARMACY INFORMATION

NAME _____ ADDRESS _____ PHONE # () ____ - ____ FAX # () ____ - ____

PLEASE READ CAREFULLY

I hereby give authorization for payment of insurance benefits to be made directly to Dr. Mathur and/or Dr. Singh (Primary Care Family Center) for services rendered. I understand that, unless prohibited by law or contract, I am financially responsible for all charges whether or not they are covered by insurance. I am also responsible for any deductible required by my insurance and for any balances due after submission to my insurance provider. I understand that if I am informed that a procedure or visit may not be covered by insurance, and I elect to have that procedure done or that visit completed, I will be responsible for full payment. In the event of default, I agree to pay all costs associated with collection of this debt and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

DATE: ____/____/____

SIGNATURE: _____