PATIENT INFORMATION FORM

Please check one of the following:
I am a Patient of: ☐ Dr. Mathur ☐ Dr. Singh

GENERAL INFORMATION:

Patient's Name: _____ Sex: ☐ M ☐ F
(First) (Middle Initial) (Last)

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

Date of Birth: _____ / _____ / _____ Social Security Number: _____-_____-_____

Home Phone No.: _____-_____-_____ Emergency Phone No.: _____-_____-_____

Mother's Name: _____ Father's Name: _____

Religion: _____ Nationality: _____

Number Yrs. In USA: _____ Language Spoken: _____

Employer's Name and Address: _____

Parent / Guardian: _____ Employer Phone No.: _____-_____-_____

Pharmacy Name: _____ Pharmacy Phone No.: _____-_____-_____

PRIMARY INSURANCE:

Name of Insurance: _____ Patient's ID Number: _____

Group Number: _____ Co-pay Amount: $ _____

Card Holder's Name: _____ Card Holder's Date of Birth: ____ / ____ / _____

Card Holder's SS#: ____-_____-_____ Relationship to Patient: _____

Deductible: $ _____

SECONDARY INSURANCE:

Name of Insurance: _____ ID Number: _____

Group Number: _____ Co-pay Amount: $ _____

PLEASE READ CAREFULLY: I hereby give authorization for payment of insurance benefits to be made directly to Dr. Mathur and/or Dr. Singh, 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 understand if I am informed that a procedure may not be covered by insurance and if I elect to have the procedure done, I will be responsible for payment. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

DATE: _____ / _____ / _____ SIGNATURE: _____

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