

PATIENT INFORMATION FORM

Hardeep Rai, MD
PHYSICIAN'S NAME

PATIENT'S FULL NAME			MAIDEN NAME		
MAILING ADDRESS		APT. NO.	PHONE NUMBER ()		
CITY		STATE	ZIP	BUSINESS PHONE ()	
SEX <input type="checkbox"/> F <input type="checkbox"/> M	MARITAL STATUS	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> OTHER	<input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	DATE OF BIRTH	PATIENT'S SOCIAL SECURITY NO.
PATIENT'S EMPLOYER'S NAME			PATIENT'S EMAIL ADDRESS		
EMPLOYER'S ADDRESS					
SPOUSE/GUARDIAN NAME		WORK PHONE #	DATE OF BIRTH	SOCIAL SECURITY NO.	
EMPLOYER			ADDRESS		
IN CASE OF EMERGENCY CONTACT		RELATIONSHIP		PHONE NUMBER ()	
PRIMARY INSURANCE COVERAGE					
INSURANCE COMPANY		INSURED DOB	<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE	<input type="checkbox"/> PARENT <input type="checkbox"/> OTHER	_____
NAME OF INSURED				COPAY AMOUNT	
INSURED'S EMPLOYER					
INSURANCE CLAIMS ADDRESS			INSURANCE PHONE NO. ()		
CITY		STATE		ZIP	
POLICY NUMBER	GROUP NUMBER		INSURED'S SOCIAL SECURITY		
INSURANCE COMPANY		INSURED DOB	<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE	<input type="checkbox"/> PARENT <input type="checkbox"/> OTHER	_____
NAME OF INSURED				COPAY AMOUNT	
INSURED'S EMPLOYER					
INSURANCE CLAIMS ADDRESS			INSURANCE PHONE NO. ()		
CITY		STATE		ZIP	
POLICY NUMBER	GROUP NUMBER		INSURED'S SOCIAL SECURITY		
ANY OTHER INSURANCE COVERAGE		<input type="checkbox"/> YES <input type="checkbox"/> NO	COMPANY NAME	PHONE NUMBER ()	
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?			PRIMARY CARE PHYSICIAN		

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize Hardeep Rai, MD, P.A. to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize the payment of medical benefits to Hardeep Rai, P.A. I understand that I am ultimately responsible for all services whether covered by insurance or not. I also authorize my physician, based on his/her discretion, to access my chart for utilization management review.

DATE: _____ SIGNATURE _____