REGISTRATION FORM

PATIENT NAME:_______________________________________ AGE: _________
GUARDIAN NAME:______________________________RELATIONSHIP:________
(If patient is a minor)
PHONE: ______________________(Home)
______________________(Work)
______________________(Cell Phone)
EMAIL ADDRESS ____
DATE OF BIRTH(Patient) __/___/____ M____ F______
ADDRESS: ____
CITY _____________________________ STATE __________ ZIP _____________
REFERRED BY:____________________________
MARITAL STATUS: Single _____ Married: _____ Divorced _____ Widowed _____
PATIENT'S OCCUPATION: ___________________________
GUARDIAN'S OCCUPATION:_________________________
(If patient is a minor)
EMPLOYER: ________________________________ ADDRESS: ________________
(Guardian's, if patient minor)
Patient SS# ____ -____-__________ Guardian's SS# _____-____-_____
(If patient minor)
DRIVER LICENSE #: __________________________
(Guardian's if patient minor)

SPOUSE OR OTHER PARENT (IF PATIENT MINOR) INFORMATION

SPOUSE NAME___________________________DATE OF BIRTH:_______________
OTHER PARENT OR GUARDIAN NAME: (If patient minor): ___________________
HIS/HER DATE OF BIRTH:________________
ADDRESS _______________________________ OCCUPATION: ________________
EMPLOYER: _____________________________ WORK ADDRESS: _____________
SPOUSE/OTHER PARENT SS#:______________
PHONE
(home):__________________(work):__________________(Cell):________________

PERSON TO CONTACT IN CASE OF AN EMERGENCY THAT DOES NOT LIVE IN YOUR HOUSEHOLD: ____
PHONE: _______________________RELATIONSHIP TO PATIENT: _____________

INSURANCE INFORMATION

PRIMARY INSURANCE:

INSURANCE COMPANY NAME:____________________________________

NAME OF THE POLICY HOLDER:__________________________________

POLICY HOLDER'S DATE OF BIRTH:_____________________

INSURANCE POLICY OR ID#:___________________________

GROUP#:_________________

SECONDARY INSURANCE:

INSURANCE COMPANY NAME:____________________________________

NAME OF THE POLICY HOLDER:__________________________________

POLICY HOLDER'S DATE OF BIRTH:_____________________

INSURANCE POLICY OR ID#:___________________________

GROUP#:_________________

AUTOMOBILE/WORKMAN'S COMP. INSURANCE:

(If injury/illness related to automobile accident or work related)

(**AUTHORIZATION MUST BE OBTAINED PRIOR TO APPOINTMENT**)

Date of accident:________________

Brief description of accident:

____

____

Automobile or Workman's comp. Insurance information:

____

____

____

IF NO INSURANCE, PAYMENT BY:

(Check one of the following)

CASH______CHECK________M/C________VISA_______

I HEREBY CONSENT AND AUTHORIZE DR. KANDALLU R. RAMESH TO PROVIDE MEDICAL CARE AND PERFORM APPROPRITE MEDICAL/SURGICAL PROCEDURES IN THE OFFICE.

X ____DATE_____________

PATIENT OR GUARDIAN