

# PATIENT INFORMATION SHEET

(PLEASE PRINT AND COMPLETE ALL SECTIONS FRONT AND BACK)

**EMERGENCY CONTACT PERSON:**

**EMERGENCY PHONE NUMBER:**

**IF PATIENT IS A MINOR PLEASE CHECK THIS BOX**

## SECTION A

## PATIENT INFORMATION

PATIENT ACCOUNT #

SOCIAL SECURITY #

PATIENT'S LAST NAME:

PATIENT'S FIRST NAME:

PATIENT'S MIDDLE INITIAL:

GENDER

(please check one box):

MALE

FEMALE

DATE OF BIRTH (MM/DD/YY):

AGE:

ADDRESS:

CITY:

STATE:

ZIP CODE:

HOME PHONE:

WORK PHONE:

CELL PHONE:

MARITAL STATUS

(please check one box):

SINGLE

MARRIED

WIDOWED

DIVORCED

EMPLOYER:

NUMBER OF CHILDREN & AGES:

PRIMARY CARE PHYSICIAN (P.C.P.):

REFERRED TO OUR OFFICE BY:

## SECTION B

## BILLING INFORMATION

(PERSON RESPONSIBLE FOR BILL, IF DIFFERENT THAN ABOVE)

NAME:

ADDRESS:

CITY:

STATE:

ZIP CODE:

HOME PHONE:

WORK PHONE:

CELL PHONE:

RELATIONSHIP TO PATIENT

(please check one box):

SPOUSE

MOTHER

FATHER

SELF

OTHER:

SOCIAL SECURITY #

EMPLOYER:

## SECTION C

## SPOUSE'S INFORMATION (IF APPLICABLE)

NAME:

SOCIAL SECURITY #

WORK PHONE:

CELL PHONE:

## SECTION D

## INSURANCE INFORMATION

### PRIMARY INSURANCE INFO

### SECONDARY INSURANCE INFO

COMPANY:

COMPANY:

ADDRESS:

ADDRESS:

INSURED (NAME ON CARD):

INSURED (NAME ON CARD):

I.D. #

DATE OF BIRTH (MM/DD/YY):

I.D. #

DATE OF BIRTH (MM/DD/YY):

GROUP #

GROUP #

GROUP NAME:

GROUP NAME:

|  |   |
|--|---|
| <b>SECTION E</b>   | <b>ADDITIONAL INFORMATION</b><br><b>(PLEASE COMPLETE IF PATIENT IS A MINOR)</b> |
| SCHOOL:  | GRADE:  |
| <b>PARENTAL INFORMATION</b>  |   |
| FATHER'S NAME:   | AGE:  |
| MOTHER'S NAME:   | AGE:  |
| PARENTS ARE<br>(please check one box): <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED |   |
| IF PARENTS ARE DIVORCED OR SEPARATED;<br>ABSENT PARENT(S) ADDRESS:   | ABSENT PARENT(S) PHONE NUMBER:  |

|                  |                       |
|------------------|-----------------------|
| <b>SECTION F</b> | <b>AUTHORIZATIONS</b> |
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**MEDICARE ONLY**

**ONE TIME AUTHORIZATION:** I request that payment of authorized Medicare benefits be made to me or on my behalf to Ralph Bharati M.D., P.A. for any services furnished by that provider. I authorize any holder of medical information about me to release to the Health Care Financial Administrations and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

**CONSENT TO TREAT:** I hereby grant consent for treatment or services to be provided by Ralph Bharati M.D., P.A. I also certify that no guarantee or assurance has been made as to the results which may be obtained.

**RELEASE OF MEDICAL INFORMATION:** I consent to the release of my medical records by Ralph Bharati M.D., P.A. for the purpose of review or audits or for necessary insurance purposes to authorized representatives of my insurance company or managed care organization.

**PATIENTS RIGHTS:** I acknowledge that I have received or reviewed a copy of the Ralph Bharati M.D., P.A. Patients Rights.

**NOTICE OF INFORMATION POLICY:** I acknowledge that I have received or reviewed a copy of the Ralph Bharati M.D., P.A. Notice of Information Policy.

**PAYMENT / INSURANCE PAYMENTS OF BENEFITS:** *I understand I am responsible for all charges for services and treatments rendered. However, as a courtesy and on my behalf, Ralph Bharati M.D., P.A. will bill my insurance company; I understand that I am responsible for deductibles, co-pays, or any amount not covered by my insurance.* I authorize payment of benefits to be made on to Ralph Bharati M.D., P.A. for medical services provided.

By signing below, I agree to all of the terms stated above:

Patient's Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Insured's Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_  
*(if other than the patient)*

Parent or Guardian's Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_  
*(for patients under 18 years old)*