

PATIENT INFORMATION

Patient Name _____ Date: _____

Address _____ City _____ State _____ ZIP _____

SS# _____ Birthdate _____ Home Phone _____

Are you a full time student? Yes ___ NO ___

Patient or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ ZIP _____

INSURANCE INFORMATION

Primary Insurance _____ ID# _____

Policy Holder Name _____ Policy Holder DOB _____

Policy Holder Relationship _____ Policy Holder SS# _____

Employer _____ Work Phone _____

Secondary Insurance _____ ID# _____

Policy Holder Name _____ Policy Holder DOB _____

Policy Holder Relationship _____ Policy Holder SS# _____

Employer _____ Work Phone _____

I hereby authorize Uma Sundaram M.D., to release such information required by my attorney and/or insurance company to secure my insurance benefits.

I hereby assign my insurance benefits herein specified and otherwise payable to me, not to exceed the doctor's fee. I understand that I am financially responsible for services not covered or deemed medically necessary by my insurance carrier.

Signature of patient(or parent/guardian if minor) Date _____

Please complete assignment of benefits on reverse side of this form.