Raghunand C. Sastry, M.D. PC.

Welcome to our office, please complete this form and return it to the receptionist who will use it to prepare your chart. **PLEASE PRINT.**

Name:_____ Date:_____

Address:_____
Street City State Zip

Date of Birth:____/____/_____ Age:____ Sex: Male ☐ Female ☐ Soc. Sec#:____-____-_____

Telephone: (____) _____-_____ Work: (____)_____-_____ Cell: (____)_____-_____

Marital Status: Single___ Married:___ Widowed:___ Divorced:___ Separated:___

Occupation:_____ Employer:_____

Employers Address:_____
Street City State Zip

Name of Primary Insured:_____ Relationship to patient:_____

Date of birth of primary insured:___/___/_____ Soc. Sec#:____-____-_____

Insurance Company:_____ ID number:_____

Name of primary **Pharmacy**:_____

Name of primary Physician_____

Name of referring doctor:_____

Person to notify in case of an emergency:

Name:_____ Relationship:_____

Address:_____
Street City State Zip

Telephone: (____) _____-_____ Work: (____)_____-_____ Cell: (____)_____-_____

Authorization to release:

I hereby authorize the above doctor to furnish the insured's insurance company all information in which the insurance company may request concerning my present claim. Your insurance company will be billed for the services rendered as a courtesy to you. It is **YOUR** responsibility to know your **CO-PAYS and/or DEDUCTIBLE** amounts. Those payments are **DUE AT THE TIME SERVICES ARE RENDERED**. It is also **YOUR RESPONSIBILITY** to make sure that you have **PRIOR AUTHORIZATION** *(if needed)* before services are rendered.

Assignment of insurance benefits:

I hereby assign to the doctor all the money to which I am entitled to for expense related to the services performed from time to time, but not to exceed my indebtedness to the doctor. I understand that I am financially responsible for any **un-paid** balances.

_____ _____

Patient signature (parent or guardian, if minor) Date