
PERSONAL INFORMATION

Last Name _____ First Name _____ M F

Date of Birth _____ SS # _____ Marital Status: S M D Sep

Street address _____

City _____ State _____ Zip _____ Tel # _____

Spouse's name _____ Spouse's Employer _____

Emergency Contact _____ Tel# _____ Relation _____

Patient's Occupation _____

PATIENT EMPLOYER INFORMATION

Employer Name _____ Tel# _____

Employer's Address _____ City/State _____ Zip _____

INSURED PERSON (If not patient)

Name _____ Tel # _____

Address _____ City/State _____ Zip _____

Relationship to patient _____ SS # _____

INSURANCE

Primary Insurance Company _____

ID# _____ Group # _____ Tel # _____

Secondary Insurance Company _____

ID # _____ Group # _____ Tel # _____

ASSIGNMENT OF BENEFITS:

I hereby authorize Ambika Bali MD Inc to apply for benefits on my behalf for covered services rendered by her order. I request that payment by my insurance company be made directly to Dr. Ambika Bali MD Inc. I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

The Open Payments database is a federal tool used to search payments made by drug and device companies to physician and teaching hospitals. It can be found at <https://openpayments.cms.gov>.

HIPPA NOTICE OF PRIVACY PRACTICES: I have read and understand the HIPPA notice.

Date _____ Signature _____