AMBIKA BALI MD, INC — PATIENT REGISTRATION

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.

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

Date _____ **Signature** _____