SUGANTHI RAVINDRAN M.D P.C

INTERNAL MEDICINE

First/ Last name: ______________________________ Date: ________

Address: ______________________________

City: ______________ State: ______ Zip: ____________

Home #: ______________ Cell: ______________

Gender: ______________ DOB: ______________

Marital Status: Please Circle: Single Married Divorced Widowed

Email Address: ______________________________

Pharmacy Name: ______________________________

Pharmacy Address: ______________________________

Pharmacy #: ______________________________

Primary Insurance: ______________________________

Secondary Insurance: ______________ ID # ______________

Insured Name: ______________________________

Ins ID #: ______________ Group #: ______________

Emergency Contact: ______________________________

Relationship: ______________________________

Emergency Contact Phone #: ______________________________

Employer Information

Occupation: ______________________ Work Phone #: ______________________

Employer Name: ____

Address: ____

City: ____________________________ State: _______ Zip: __________________

Authorization to Release Information and Pay Insurance Benefits

I understand that I am financially responsible for charges not covered by this authorization. I hereby authorize the release of medical information pertaining to medical treatments requested by my health insurance carrier of the Health Care Financing Administration and its agencies for determination of benefits coverage. I authorize payment directly to my insurance provider, or his/her billing organization.

Signature: __________________________________ Date: ______________________

Medicare

I request payment of medicare benefits be made on my behalf to my physician for services rendered to me. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agencies any information needed to determine these benefits payable for related services.

Signature: ____

Physician Signature: ____