PATIENT REGISTRATION FORM

Patient Name: ____ Age: _____________

Address: __________________________ City: ____________ State: _____ Zip Code: ______

Home: __________________ Cell: _____________________ Work:__________________

Date of Birth: ___/___/____ MALE / FEMALE

E-Mail: ____

Marital Status: (Circle One) Married Divorced Single Widowed Other

Patient Employer: ____

INSURANCE INFORMATION

Primary Insurance: ____

Insured Name: __________________________________Date of Birth:_________________

Relationship to the Insured: ____

Insured Employer: _______________________________ Insurance Phone #: ____________

Member ID: ___________________________________ Group #: ____________________

Secondary Insurance: ____

Insured Name: _________________________________ Date Of Birth: _________________

Relationship to the Insured: ____

Insured Employer: _____________________________ Insurance Phone #: ______________

Member ID: _________________________________ Group #: ______________________

I hereby authorize Archana Ganaraj, M.D., W. Lee Bourland, M.D., Carolyn Thomas, M.D. to release any information acquired in the course of my examination and treatment to other physicians and my insurance companies, as needed for my care and claim processing. I hereby authorize my insurance companies to send benefits for services rendered to my physician. I also understand that I am responsible fjor all charges incurred excluding any contractual adjustments between my insurance company and the physician.

Patient Signature: _______________________________ *Date* ___/___/_____