

# Vijay K. Anand. MD, P.C.

## PATIENT INFORMATION FORM

PATIENT LAST NAME: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_

PATIENT FIRST NAME: \_\_\_\_\_ Home Phone #: \_\_\_\_\_ Mobile #: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ Apartment #: \_\_\_\_\_ Male \_\_\_ Female \_\_\_

CITY/ STATE/ ZIP CODE: \_\_\_\_\_

MARITAL STATUS: \_\_\_ MARRIED \_\_\_ SINGLE \_\_\_ WIDOW (ER) \_\_\_ DIVORCED IS THIS A CHILD/DEPENDENT? \_\_\_ Y \_\_\_ N

\*\* HOW WERE YOU REFERRED TO OUR OFFICE? \_\_\_ FRIEND \_\_\_ FAMILY MEMBER \_\_\_ INSURANCE BOOK \_\_\_ HOSPITAL

\_\_\_ DOCTOR: PLEASE INDICATE NAME \_\_\_\_\_ MD. PHONE # \_\_\_\_\_

OTHER: \_\_\_\_\_

\*\*\* NAME OF YOUR PRIMARY DOCTOR? \_\_\_\_\_ MD.'S PHONE NUMBER: \_\_\_\_\_

### **EMPLOYER INFORMATION:**

NAME: \_\_\_\_\_ WORK PHONE#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

\*\*\*\*\* IF THIS IS A WORKER'S COMPENSATION OR A NO-FAULT CASE. PLEASE ADVISE RECEPTIONIST!!!!!! \*\*\*\*\*

### **INSURANCE INFORMATION:** (PLEASE SUBMIT INSURANCE CARDS TO RECEPTIONIST)

INSURANCE CO. NAME: \_\_\_\_\_ POLICY #: \_\_\_\_\_

GROUP #: \_\_\_\_\_ CATEGORY CODE (if applicable): \_\_\_\_\_

PRIMARY CARD HOLDER: \_\_\_ MYSELF \_\_\_ SPOUSE \_\_\_ PARENT/GUARDIAN (IF SPOUSE/PARENT, COMPLETE BELOW)

CARDHOLDER'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_ SS#: \_\_\_\_\_

SECONDARY INSURANCE PLAN (if any): \_\_\_\_\_ POLICY #: \_\_\_\_\_

GROUP #: \_\_\_\_\_ CATEGORY # (if applicable): \_\_\_\_\_

PRIMARY CARD HOLDER: \_\_\_ MYSELF \_\_\_ SPOUSE \_\_\_ PARENT/GUARDIAN (IF SPOUSE/PARENT, COMPLETE BELOW)

CARDHOLDER'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_ SS#: \_\_\_\_\_

**WHO CAN WE CALL IN CASE OF EMERGENCY?** \_\_\_\_\_ PHONE # \_\_\_\_\_

I request that payment of authorized Medicare or other insurance carrier benefits be made on my behalf to the physician(s) of the Vijay K. Anand, MD P.C. for any services furnished me by those physicians. I authorized any holder of medical information about me to release to my insurance carrier or the Health Care Financing Administration and it's agents any information needed to determine these benefits or the benefits payable for related services. Furthermore, I understand the annual deductible amounts and all co-insurance amounts are my responsibility. If I have assigned my medical benefits to any other party (managed care or plans that we do not participate in), rendering this office ineligible for payment, I understand that I will be responsible for the entire bill for services.

**I HAVE READ THIS INFORMATION AND UNDERSTAND.**

PATIENT: \_\_\_\_\_ (PARENT/GUARDIAN IF MINOR) DATE: \_\_\_\_\_