PATIENT INFORMATION

Patient Name_____ Date:_____

Address_____ City_____State____ ZIP_____

SS#_____ Birthdate_____Home Phone _____

Are you a full time student? Yes___ NO ____

Patient or Parent's Employer _____Work Phone _____

Business Address _____ City _____State _____ZIP _____

INSURANCE INFORMATION

Primary Insurance_____ ID#_____

Policy Holder Name _____Policy Holder DOB_____

Policy Holder Relationship _____Policy Holder SS# _____

Employer_____Work Phone _____

Secondary Insurance_____ ID#_____

Policy Holder Name _____Policy Holder DOB_____

Policy Holder Relationship _____ Policy Holder SS# _____

Employer_____ Work Phone _____

I hereby authorize Uma Sundaram M.D., to release such information required by my attorney and/or insurance company to secure my insurance benefits.

I hereby assign my insurance benefits herein specified and otherwise payable to me, not to exceed the doctor's fee. I understand that I am financially responsible for services not covered or deemed medically necessary by my insurance carrier.

_____Date _____

Signature of patient(or parent/guardian if minor)

Please complete assignment of benefits on reverse side of this form.