Amba R. Krishnan, M.D.

Patient Information Form

Please Print Clearly

Name: _____

Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip code: _____

Social Security Number: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Marital Status: Married _____ Single _____ Widowed _____ Other _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Employer/Retired from: _____

Work Phone: (____) _____

Emergency Contact: _____ Phone: (_____) _____

Allergies: _____

_____

Insurance Information

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-pays and/or balance not paid by your insurance. In order to control your cost of billing, we request that any co-payments are to be made at the end of each visit.

Authorization to pay: I hereby authorize payment directly to the above mentioned physician for surgical and/or medical benefits, if any, otherwise payable to me for the services, not to exceed the reasonable and customary charge for these services.

I understand that I am financially responsible for the charges not covered by this authorization or deemed my responsibility by my insurance coverage.

Patient's Signature: _____ Date: _____

Print Name: _____