PATIENT INFORMATION SHEET

NAME:_____ AGE:_____ BIRTHDATE:_____ SEX:_____

ADDRESS:_____ APT #:_____ CITY:_____ STATE: _____ ZIP:_____

HOME PHONE:(_____)_____ WORK PHONE: (_____)_____ EXT:_____

CELL PHONE: (_____)_____ OTHER PHONE: (_____)_____ WHO/WHAT:_____

AT WHICH OF THE ABOVE PHONES MAY WE LEAVE MESSAGES FOR YOU? ☐HOME ☐CELL ☐WORK ☐OTHER

SOCIAL SECURITY #:_____-_____-_____ ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐WIDOWED

EMPLOYED BY:_____ BUSINESS ADDRESS:_____

CITY:_____ ZIP:_____DRIVERS LIC #:_____ STATE: _____ OCCUPATION: _____

EMERGENCY CONTACT NAME: _____ PHONE #: (_____)_____

IF RESPONSIBLE PERSON/PARTY IS OTHER THAN PATIENT…

PERSON RESPONSIBLE FOR PAYMENT:_____

RELATIONSHIP TO PATIENT:_____ SS#_____DOB: _____

ADDRESS: _____ APT #: _____ CITY: _____ ZIP:_____

EMPLOYED BY: _____ OCCUPATION: _____

BUISNESS ADDRESS: _____ SUITE #:_____ CITY:_____ ZIP: _____

INSURANCE INFORMATION:

DO YOU HAVE MEDICARE? _____ IF YES, MEDICARE ID #: _____

DO YOU HAVE MEDI-CAL? _____

NAME OF OTHER INSURANCE COMPANY: _____

ARE YOU THE INSURED/CARD HOLDER OR A DEPENDENT? _____

RELATIONSHIP TO INSURED?: _____INSURED'S NAME: _____

INSURED'S BIRTHDATE: _____/_____/_____**INSURED'S SOCIAL SECUIRTY #**:_____-_____-_____

FAMILY DOCTOR'S NAME: _____ PHONE NO: (_____)_____

I hereby authorize the release of any medical information necessary to process this claim.

I request and authorize direct payment of any government and/or insurance benefits to Sunil G. Bhandarkar, Inc. for all services provided.
In the event that my insurance does not pay, is delayed in paying, or pays for only part of my incurred charges, I agree to be entirely responsible for the balance.

Responsible party's signature (REQUIRED): _____

Responsible party's name (print):_____

TODAY'S DATE: _____

WHO REFERRED YOU TO DR. BHANDARKAR ?_____