

**PATIENT REGISTRATION
PLEASE PRINT**

LAST NAME _____ FIRST _____ INIT _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE# _____ CELL PHONE# _____

BIRTHDATE _____ SS# _____ MARITAL STATUS M _____ S _____ W _____ D _____

PATIENT'S EMPLOYER _____ WORK PHONE# _____

WORK RELATED INJURY YES or NO

PRIMARY CARE PHYSICIAN _____ PHONE# _____

REFERRING PHYSICIAN NAME _____ PHONE# _____

EMERGENCY CONTACT:

NAME _____ PH # _____ RELATIONSHIP TO YOU _____

INSURANCE AND BILLING AUTHORIZATION PLEASE PROVIDE INSURANCE CARDS AND PHOTO ID

PRIMARY INSURANCE PLAN _____

PRIMARY INSURED'S NAME (IF OTHER THAN YOURSELF) _____

ADDRESS _____

PHONE# _____

BIRTHDATE _____ SS# _____ RELATIONSHIP TO YOU _____

It is your responsibility to be familiar with the terms, deductibles, referral requirements, and co-pays of your insurance company. Failure to provide us with the correct insurance information or follow their guidelines may result in NON-COVERED expenses which will become your responsibility. If the Doctor does not participate with your insurance company, payment is due at the time of service.

I know I may be responsible for a portion or all of the charges. I agree to pay Dr. Sham L. Gupta for services not covered by my insurance company, co-pays, or deductibles. I authorize the release of any medical information necessary for my insurance company to process this claim. I also authorize payment of medical benefits to the physician for services rendered.

SIGNATURE _____ DATE _____