

**PATIENT INFORMATION SHEET**

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MN \_\_\_\_\_  
SEX \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_ MARITAL STATUS    S M D SEP W  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE(\_\_\_\_) \_\_\_\_\_ WORK PHONE(\_\_\_\_) \_\_\_\_\_ EMAIL \_\_\_\_\_  
SS# \_\_\_\_\_ EMPLOYER \_\_\_\_\_

**MEDICATION ALLERGIES** \_\_\_\_\_

**PARTY RESPONSIBLE FOR PAYMENTS**

NAME \_\_\_\_\_ RELATION TO PT \_\_\_\_\_  
ADDRESS \_\_\_\_\_ HOME PHONE(\_\_\_\_) \_\_\_\_\_  
CITY, STATE, ZIP \_\_\_\_\_ WORK PHONE(\_\_\_\_) \_\_\_\_\_  
SS# \_\_\_\_\_ DOB \_\_\_\_\_ EMPLOYER \_\_\_\_\_

**INSURANCE INFORMATION**

COMPANY NAME \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_  
POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_  
HMO PPO MAILING ADDRESS \_\_\_\_\_  
COPAY \_\_\_\_\_ DEDUCTIBLE \_\_\_\_\_ REFERRAL REQUIRED YES \_\_\_ NO \_\_\_  
NAME OF REFERRING PHYSICIAN \_\_\_\_\_ UPIN# \_\_\_\_\_  
ADDRESS \_\_\_\_\_ PHONE(\_\_\_\_) \_\_\_\_\_

**SECONDARY INSURANCE**

INSURED'S NAME \_\_\_\_\_ RELATION TO PT \_\_\_\_\_  
COMPANY NAME \_\_\_\_\_ PHONE(\_\_\_\_) \_\_\_\_\_  
POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_ DOB \_\_\_\_\_

I authorize Dr. Kris Bhat to release medical records to insurance for payment and for services and to the referring or primary care physician or other health care providers. I authorize and assign insurance benefits to Kris Bhat, MD for services rendered. I am responsible for deductibles, coinsurance, copays, and referrals when needed.

Signature \_\_\_\_\_ Date \_\_\_\_\_ Minor's Name \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_