

RAM MUDIYAM, M.D., INC.

Patient Information Sheet

(Please Print)

(Please Print)

NAME: Last _____ First _____ Middle _____			AGE _____	TODAY'S DATE _____
ADDRESS: Street _____ City _____ State _____ Zip _____			HOME PHONE _____	
FEMALE <input type="checkbox"/>	BIRTHDATE _____	SINGLE <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	DRIVERS LIC. NO. _____	SOC. SEC. NO. _____
MALE <input type="checkbox"/>		MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
EMPLOYER (Name and FULL Address) _____			WORK PHONE _____	CELL PHONE _____
OCCUPATION _____			Have you been our patient before? Yes <input type="checkbox"/> No <input type="checkbox"/>	
			Approximately When? _____	

RESPONSIBLE PARTY (if other than patient) _____

RELATION TO PATIENT _____			SOC. SEC. NO. _____	
Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other _____ D.O.B. _____				
NAME: Last _____ First _____ Middle _____			HOME PHONE _____	
ADDRESS: Street _____ City _____ State _____ Zip _____				
EMPLOYER (Name and FULL Address) _____			WORK PHONE _____	

REFERRED BY: Patient, Doctor, Coaching Staff, Other (Please enter name) _____
 Name, Address, Phone No. of Nearest Relative or Friend Not Living With You _____

<p style="text-align: center;">PATIENTS PLEASE NOTE</p> <p>If you are a member of any HMO - (Health Maintenance Organization), please advise us. Your HMO authorization must be in our office prior to services or you may be responsible for charges.</p>	<p>IF YOU WERE INJURED, were you injured:</p> <p><input type="checkbox"/> On your job? <input type="checkbox"/> Did you notify your employer? <input type="checkbox"/> In auto accident? <input type="checkbox"/> At home? <input type="checkbox"/> Other: _____</p> <p>Date of Injury _____ Attorney Name _____ Attorney Phone _____</p>	<p>Are you off work because of this problem? _____</p> <p>Date last worked _____</p> <hr/> <p>* I elect to choose my "out of network" benefits.</p> <p>Signature _____</p>
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INSURANCE INFORMATION

INSURANCE CARRIER _____			INSURED _____	
ADDRESS: Street _____ City _____ State _____ Zip _____			CERT. NO. _____	GROUP NO. _____
INSURANCE CARRIER (2nd Insurance) _____			INSURED _____	
ADDRESS: Street _____ City _____ State _____ Zip _____			CERT. NO. _____	GROUP NO. _____

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION:

I hereby irrevocably assign the insurance benefit payment, both basic and major medical, to which I am entitled directly to the doctor rendering service. I understand that I am financially responsible for the charges not covered by the assignment. A photostat of this authorization is accepted with the same authority as the original. I hereby authorize doctor rendering service to release any information required in the course of my examination or treatment.

Insured Signature _____ Date _____

Signed: Patient or Parent of Minor

A copy of these authorizations shall be valid as the original.