

Date: \_\_\_\_\_

**CONFIDENTIAL RECORD:**

Information contained here will not be released unless you have authorized us to do so.

LAST NAME \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MIDDLE \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_ PRIMARY CARE PHYSICIAN: \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

MEDICARE NO. \_\_\_\_\_

SS# \_\_\_\_\_ HOME PHONE: \_\_\_\_\_ WORK PHONE \_\_\_\_\_

SEX: M F MARITAL STATUS: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

PERSON TO NOTIFY: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE NO. \_\_\_\_\_

DATE OF LAST PHYSICAL EXAM: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

PATIENT'S EMPLOYER: \_\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_ SPOUSE'S D.O.B. \_\_\_\_\_

SPOUSE'S EMPLOYER: \_\_\_\_\_

SPOUSE'S SOCIAL SECURITY NO. \_\_\_\_\_

INSURANCE INFORMATION: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
NAME OF PERSON INSURED: \_\_\_\_\_

NAME OF INSURANCE COMPANY: \_\_\_\_\_ EMPLOYER OF INSURED: \_\_\_\_\_

CONTRACT #: \_\_\_\_\_ GROUP#: \_\_\_\_\_

INSURANCE BILLING ADDRESS: \_\_\_\_\_ SS# OF INSURED \_\_\_\_\_

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO DR. JAIN OF THE AMOUNT DUE ME IN MY PENDING CLAIM FOR MEDICAL EXPENSES PAYABLE UNDER THE TERMS OF MY INSURANCE.

I AGREE THAT ANY BALANCE NOT COVERED BY INSURANCES WILL BE PAID BY ME.

I ALSO AUTHORIZE ANY HOSPITAL OR CLINIC TO PROVIDE FULL DETAILS OF MY MEDICAL HISTORY AND TREATMENT TO DR. JAIN.

IN CASE OF DEFAULT ON PAYMENT FOR SERVICES RENDERED, REASONABLE COLLECTION FEES AND/OR ATTORNEY FEES WILL BE THE RESPONSIBILITY OF THE UNDERSIGNED.

WE DO NOT CHARGE FOR THE PROCESSING OF SPECIMENS, HOWEVER IF LAB WORK IS NECESSARY (CULTURE, PATHOLOGY, ETC.). YOU WILL BE BILLED BY THE LAB DIRECTLY. WE DO NOT CHARGE A HANDLING FEE.

WE WILL PROVIDE AN ATTENDENT DURING THE EXAM IF YOU REQUEST ONE TO BE PRESENT. NOTIFY THE DOCTOR AND/OR STAFF.

(A COPY OF THIS SIGNATURE IS AS VALID AS THE ORIGINAL)

SIGNATURE OF PATIENT

DATE