RAM DANDILLAYA, M.D.

A PROFESSIONAL CORPORATION

*Patient Registration Form*

**Please Provide Insurance & Driver License Cards**

NAME OF PATIENT: ______________________________________________
LAST FIRST MIDDLE

SEX: □M □F DATE OF BIRTH: ____________ MARITAL STATUS: ______ HOME # _______________

DRIVER LICENSE#:_________________ SOC.SEC. #: _______________________MOBILE #: ______________

HOME ADDRESS: ________________________________________ WORK # ______________
CITY STATE ZIPCODE

EMAIL: ______________________________________________

EMPLOYER: ______________________________ OCCUPATION: ______________________

ADDRESS: ________________________ CITY: ______________ STATE: _____ ZIPCODE: __________

NAME OF SPOUSE: ________________________________ AGE: ___ DATE OF BIRTH: ___________

DRIVER LICENSE#:_________________ SOC.SEC. #: _______________________MOBILE #: ______________

SPOUSE EMPLOYER: ________________________ OCCUPATION: ______________________

NAME AND PHONE NUMBER OF EMERGENCY CONTACT PERSON NOT LIVING WITH YOU:

NAME: __________________________________ RELATIONSHIP TO PATIENT: ________________

ADDRESS: ______________________________________________

NAME: __________________________________ RELATIONSHIP TO PATIENT: ________________

ADDRESS: ______________________________________________

REFERED TO DOCTOR BY: ________________________________________

DO YOU HAVE MEDICAL INSURANCE? □ YES□ NO ARE YOU A CASH PAYING PATIENT: □ YES□ NO

□MEDICARE □MEDI-CAL □MEDICARE/HMO □MEDICAL/HMO □HMO □PPO □CASH

PRIMARY INSURANCE: ________________________________________

NAME OF INSURED: □ SELF □ OTHER ______________________________ DATE OF BIRTH: __________

RELATIONSHIP TO PATIENT: _________________ ID# ______________________ GROUP# ______________

ADDRESS OF INSURANCE COMPANY: ________________________________________

CITY: ____________________ STATE: _________________ZIP: ________________NUMBER:_____________

SECONDARY INSURANCE: _________________ SUBSCRIBER NAME: ______________ DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: ________________________ ID# ______________________ GROUP# ________

ADDRESS OF INSURANCE COMPANY: ________________________________________

CITY: ____________________________STATE:_______ZIP:________PHONE NUMBER: ____________________

I HEREBY AUTHORIZE PAYMENT OF ANY MEDICAL AND SURGICAL INSURANCE BENEFITS TO RAM DANDILLAYA, M.D. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. IF CO-PAYMENTS AND /OR DEDUCTIBLES ARE DESIGNATED BY MY INSURANCE COMPANY OR HEALTH PLAN, I AGREE TO PAY THEM TO RAM DANDILLAYA, M.D. I AUTHORIZE RAM DANDILLAYA, M.D. TO RELEASE ANY MEDICAL INFORMATION REQUIRED TO PROCESS ANY CLAIMS FOR REINBURSEMENTS ON MY BEHALF. A COPY OF THIS AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL

PATIENT SIGNATURE: ______________________________________DATE:__________________________