Dr. S. Majumder & Dr. R. Palnitkar

(Please Circle the Physician you are seeing)

Please Print Clearly and Legible

Patient Information form

Today's Date: _____ Referring/PCP Physician Name_____

Date of COVID-19 vaccine:

1st:_____2nd_____Booster_____

Patient Information:

Last Name: _____ First _____ M_____ Gender: **F M**

Street Address: _____ City: _____ State&Zip_____

Date of Birth: _____ Mobile _____ Home_____

Employer: _____ Occupation: _____Work_____

Preferred Pharmacy Name: _____ Phone: _____

Pharmacy Street_____ City_____

Marital Status: S / M/ DIV / Sep / Wid **Email:** _____

Insurance Information: Please give your Insurance Card(s) to Receptionist

All information must be filled out completely

Person Responsible for Bill: _____ DOB _____

Address if Different _____ City _____ State & Zip _____

Relationship to patient: _____ Employer_____ Work#_____

Please Indicate **Primary Insurance**_____ **2nd Insurance**_____

The Information Below Must Be Filled Out Completely to Bill Your Secondary Insurance

Note: If any of these questions are not fully answered, we will not bill your secondary because the claim will be denied for incomplete or invalid information.

Subscriber's Name: _____ DOB _____

Address_____ City_____ State & Zip_____

Relationship to Patient: Self / Spouse / Child / Other

In Case of Emergency:

Name _____ Relationship to Patient _____

Home# _____ Work# _____

Last Pneumonia Vaccine: Date _____

Last Flu Vaccine: Date _____

Professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance payments. However, the patient is responsible for all fees, Regardless of Insurance Coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our Bookkeeper.

Insurance Authorization and Assignment

I Hereby Authorize Dr's R. Palnitkar & S. Majumder to furnish information to Insurance carriers concerning my illness and treatments, and I hereby assign to the physician (s) all payments for medical services rendered to my dependents or myself. I understand that I am Responsible for any amount not covered by Insurance.

Date ____ /____ /____ Signature: _____

I understand that if My Insurance Company required Pre-Authorization and / or Physician Referral for Consultation and / or Office visits, and I don't supply Dr's R. Palnitkar & S. Majumder with this Pre-Authorization and / or referral. Then I will be responsible for paying my bill.

Date ____ / ____ /____ Signature: _____

I Hereby Authorize Dr's R. Palnitkar & S. Majumder to include Human Immunodeficiency Virus Test Results in Reports to Insurance carriers.

Date ____ / ____ / ____ Signature: _____

Next of Kin?

Name:_____Relation:_____

Telephone: (Home)_____ (Mobile)_____

Do you have an Advance Directive? Yes ❒ No ❒

_____

Do you have a Designated Power of Attorney? Yes ❒ No ❒

Name: _____

Telephone: _____

Relationship to Patient:

_____