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NEW PATIENT INFORMATION

PATIENT NAME:

(Last Name)

(First Name)

(MI)

Email:

Home Phone:

Cell/Alternate Phone:

Sex: ☐ Male ☐ Female

Birth Date: Age:

SS#

Home Address: Stress Address

APT#

City

ST

Zip

Marital Status: ☐ Married ☐ Single ☐ Divorced

Reason For Visit:

Primary Care

Physician:
Phone:

Referring Physician:
Phone:

Insurance Provider:

Insurance ID#

Insurance Group #

Insurance Provider Phone #

Employer:

Employer Address:

Work Phone:

☐ Full-Time ☐ Part-Time ☐ Retired

Person to be reached in
case of emergency:

Relation:

Phone:

I hereby authorize Dr. Shashi Dharma's office to release written or verbal information to my doctor or insurance carrier (if the information is requested). In consideration of services rendered, I hereby assign to Dr. Dharma benefit payments due from my insurance company for medical expenses incurred which are payable to me.

I have been informed of or received a copy of the "Notice of Privacy Practices."

Payment is due at time of service! This includes all copays, deductibles, and any other non-covered items.

**A \$25 fee will be charged for all "NO SHOW" appointments
not canceled at least 24 hours in advance.**

I accept the above terms and am responsible for any incurring charges.