DR MANOHAR G REDDY, MD PA

2551 W Eau Gallie Blvd, Ste 101 Melbourne, FL 32935

PATIENT DEMOGRAPHICS

PATIENT NAME: _____ **DOB:** _____ **SSN:** _____

ADDRESS: _____ **CITY/STATE/ZIP:** _____

GENDER: ❑ Male ❑ Female **E-Mail:** _____

HOME: _____ **CELL**: _____ **WORK:** _____ EXT: _____

EMERGENCY CONTACT: _____ **PHONE:** _____ **Relationship:**_____

PHARMACY NAME: _____ **LOCATION:** _____

MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED ❑ SEPARATED ❑ PARTNER

ETHNICITY: ❑ HISPANIC OR LATINO ❑ NOT HISPANIC OR LATINO

RACE: ❑ AMERICAN INDIAN/ALASKA NATIVE ❑ BLACK/AFRICAN AMERICAN ❑ OTHER RACE ❑ WHITE

REQUEST PORTAL ACCESS (email address required above); ❑ **YES** ❑ **NO**

INSURANCE

PRIMARY CARRIER: _____ **PHONE:** _____
PRIMARY INSURED: _____ **RELATIONSHIP:** _____
POLICY # _____ **GROUP #**_____

SECONDARY CARRIER: _____ **PHONE:** _____
PRIMARY INSURED: _____ **RELATIONSHIP:** _____
POLICY # _____ **GROUP #** _____

AGREEMENT:

LIFETIME MEDICARE B SIGNATURE AUTHORIZATION: For services beginning today, I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of **ABOVE** any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment.

FOR MEDIGAP INSURED'S AUTHORIZATION: I request that payment for authorized Medigap Benefits be made on my behalf to **ABOVE** for any services furnished me by **ABOVE.** I authorize any holder of medical information about me to release my Medigap Insurer any information needed to determine these benefits or the benefits payable for related services. I understand that I do not need to provide my supplemental Insurer with information concerning this Medicare claim, because my signing this authorization will cause Medicare payment information to cross over automatically.
(ABOVE must have accurate Medigap information - please examine the information closely at each visit.)

INSURANCE AUTHORIZATION: I assign the benefits payable for physician services to the **ABOVE** physician and organization furnishing the services and authorize **ABOVE** to submit a claim to my health insurance carrier as needed for payment to the physician or me. I authorize any holder of medical or other information about me to release to my insurance carrier any information needed for this or a related claim. A copy of this authorization may be used in lieu of the original. This authorization and assignment are to be a continuing one remaining in force until revoked in writing by the undersigned.

I have read and agree to the authorization, release of information, and assignment of benefits. I am aware of the Notice of Privacy Practices and may obtain a copy at any time.

_____ _____

PATIENT/LEGAL GUARDIAN SIGNATURE **DATE**