OFFICE OF DR. MANOHAR REDDY

REGISTRATION INFORMATION

(PLEASE PRINT)

Date _____ Home Phone ( ) _____

Patient _____ SSN _____- _____-_____
Last Name First Name

Street Address _____

City _____ State _____ Zip _____

Sex ❑M ❑F Age ____ Birthdate _____ ❑Single ❑Married ❑Widowed ❑Divorced

Patient Employed by _____

Business Address _____

Occupation _____ Business Phone ( ) _____

Spouse (or responsible party) Name _____ Birthdate _____

Business Name & Address _____

Occupation _____ Business Phone ( ) _____

Who is responsible for this account? _____ Relationship to patient _____

Do you have medical insurance? ❑ no ❑yes

If yes:

Name of Primary Insurer _____

Contract # _____ Group # _____ Subscriber # _____

Name of Secondary Insurer (if any) _____

Contract # _____ Group # _____ Subscriber # _____

May we contact you at home? ❑no ❑yes at work? ❑no ❑yes

If you have an answering machine, may we leave a message on it? ❑ no ❑yes

Is there someone whom we can talk to regarding your health information, appointments, test results, etc. besides you? ❑ no ❑ yes

If yes, Name _____Relationship to You _____ Phone ( ) _____

Name _____Relationship to You _____ Phone ( ) _____

In case of emergency, who should be notified? _____

Relationship to Patient _____ Phone # _____

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(PLEASE PRINT)

Please list other doctors you have seen in the past 5 years:

1. _____ City/State _____
   (General Practitioner, Specialist, or other)

   Reason for seeing _____

2. _____ City/State _____
   (General Practitioner, Specialist, or other)

   Reason for seeing _____

How did you learn of our practice? _____

Whom may we thank for referring you? _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of Insurance Company

And assign directly to Dr. _____ all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date

OFFICE NOTES

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