**PATIENT REGISTRATION**

**TODAY’S DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ REFERRING PHYSICIAN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

PATIENTS’ FULL NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE\_\_\_\_\_\_\_\_\_\_\_ BIRTHDATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ST\_\_\_\_\_ ZIP CODE\_\_\_\_\_\_\_\_\_\_\_\_

MARITAL STATUS: [ ] S [ ] M [ ] D [ ]W SEX: [ ]F [ ]M SOCIAL SECURITY #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OCCUPATION \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOME PH#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL PH#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PH#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY PHYSICIAN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY / NEXT OF KIN CONTACT INFORMATION**

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PH#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RESPONSIBLE PARTY (GUARANTOR) INFORMATION**

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_BIRTHDATE\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS (if different from patient)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUBSCRIBERS SOCIAL SECURITY #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMPLOYER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYERS ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OTHER CONTACT INFORMATION – NOT LIVING WITH PATIENT**

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELATIONSHIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE READ BEFORE SIGNING**

I HEREBY AUTHORIZE SAMBASIVA R. MARUPUDI TO BE MY ATTENDING PHYSICIAN AND TO ADMINISTER TO ME ANY EXAMINATION, TREATMENT OR MEDICATION HE DEEMS THERAPUTIC TO MY PRESENTING COMPLAINT. IN ADDITION, I GIVE MY CONSENT TO PROCEDURES OR ANY MINOR SURGICAL PROCEDURE THAT MAY BE NECESSARY. I FURTHER AUTHORIZE SAMBASIVA R. MARUPUDI MD OR HIS REPRESENTATIVE TO RELEASE TO MY INSURANCE COMPANY OR ITS REPRESENTATIVE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME DURING THE PERIOD OF SUCH MEDICAL OR SURGICAL CARE. I ALSO AUTHORIZE AND REQUEST THAT MY INSURANCECOMPANY PAY DIRECTLY THE AMOUNT DUE IN MY PENDING CLAIM FOR BASIC MEDICAL, ENDOSCOPY PROCEDURES AND/OR MINOR SURGICAL TREATMENT FOR SERVICES RENDERED, BY REASON OF SUCH TREATMENTS OR SERVICES.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE DATE**