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PATIENT REGISTRATION

Patient Last Name:_____ **First Name:**_____ **MI:**____

Address:_____ City:_____ State:_____ ZIP:_____

Home: (___) _____ - _____ Work: (___) _____ - _____ Cell: (___) _____ - _____

Birthdate:____/____/____ Gender: ☐ Male ☐ Female SSN:_____ - _____ - _____

Email Info:_____ **Referring / Primary Care Physician:**_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Unknown

Student Status: ☐ Not a student ☐ Full-Time Student ☐ Part-time Student

Employment: ☐ Employed ☐ Not Employed ☐ Self-employed ☐ Retired ☐ On Military Active Duty ☐ Unknown

Employer name:_____ Job Description:_____

Primary Insurance Information (Please provide card – for copy of front and back)

Indicate patient's relationship to primary insured: ☐ Self ☐ Spouse ☐ Child ☐ Other (POA, Attorney, etc.)

POLICY HOLDER'S NAME (If self, write self):_____

Policy Holder's Date of Birth: ____/____/____ Policy Holder's SSN#:_____ - _____ - _____

Insurance Company Name:_____

Policy Number:_____ Group Number:_____ Copay Amt: $_____

Secondary Insurance Information (Please provide card – for copy of front and back)

Indicate patient's relationship to primary insured: ☐ Self ☐ Spouse ☐ Child ☐ Other (POA, Attorney, etc.)

POLICY HOLDER'S NAME (If self, write self):_____

Policy Holder's Date of Birth: ____/____/____ Policy Holder's SSN#:_____ - _____ - _____

Insurance Company Name:_____

Policy Number:_____ Group Number:_____ Copay Amt: $_____

Emergency Contact:_____ Contact Number:_____ Relationship: _____

Pharmacy Name:_____ Pharmacy number: (___) _____ - _____

Please read and sign:
I authorize the release of any of my medical, psychiatric, or other information necessary to process any claim and to provide information to another health care provider when necessary to coordinate treatment. I also authorize payment of benefits to Sitara Kommareddi, M.D.,PLLC I fully understand that if my insurance denies payment for any service defined as "non-covered", I will be responsible for that amount due. . In the event this account must be placed with Surety Acceptance Corporation for collection; patient or responsible party agrees to pay all collection costs.

SIGNATURE:_____ **DATE:**_____
Patient / Parent or Guardian