Santi Rao, MD **Spinal Disorders and Surgery**

www.SantiRaoMD.com

Today's date ______________

Patient Name:

[Last Name]______________________________________ [First Name]________________________________

Your Age: ____________ Date of Birth: _____/_______/_______

Mailing Address: ____City: ___________________

State: _______ Zip Code: _______

Calif. Driver's License: __________________________ Social Security#: ____________________________

Home Phone: (____)____________________________**Work Phone**: (____)________________________

Cell Phone: (____)____________________________**Email address**: ____________________________

Name of Spouse: _________________________ if under 18, name of parents: ________________________

Emergency Contact: __________________________________ Phone (____)____________

Employer and address: ____

Your Occupation: ____

Your family physician:__________________________________ Phone (____)____________

Would you mind telling us who referred you? / How did you hear about this office?

____

Private Insurance Information (please present all insurance cards to receptionist)

Name of insurance company___________________________ Subscriber_______________________________

ID#____ Social Security #__________________________

If there is a second health plan, please include:

Name of insurance company___________________________ Subscriber_______________________________

ID#____ Social Security #__________________________

Work Related / Car Accident Related Problems:

Do you have an attorney? ---- ----- ----- ---- ---- ----- YES NO

Attorney name ____ Phone (____)____________

Have you filed a claim for a work-related injury? YES NO

If you are claiming a *work related injury – please give us your information -*

Insurance company: __________________________ Date of injury ___________

Claims examiner name: ________________________ Phone (____)____________

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of any medical information necessary to process this claim

Print and sign name (patient or authorized person) Date

ASSIGNMENT OF INSURANCE BENEFITS

I hereby instruct my insurance company, or attorney to pay directly to my physician any benefits allowable for the professional services rendered to me.

Print and sign name (insured or authorized person) Date

ASSIGNMENT OF SECONDARY INSURANCE BENEFITS

I hereby instruct my secondary insurance company to pay directly to my physician any benefits allowable for the professional services rendered to me.

Print and sign name (patient or authorized person) Date

LIABILITY OF UNPAID BALANCE

Any sum of money paid under this assignment shall be credited to my account and I shall be personally liable for any unpaid balance.

Print and sign name (patient or authorized person) Date

PERMISSION TO TREAT A MINOR

I/We grant consent to have my/our child receive the necessary medical treatment as prescribed by the physician.

Print and sign name (parent or guardian) Date

THANK YOU!