Chandrahas Agarwal, M.D.

PATIENT INFORMATION

Last Name: _____ First Name: _____

Address: _____ City: _____Zip _____

Social Security Number: _____DOB: _____Marital Status: S M D W Sex: M / F

Preferred Phone Number: _____ Additional Phone Number: _____

Employer: _____Address: _____

If patient is a senior with legal Power of Attorney please give PO name: _____

Primary Care Physician: _____

Address: _____ Phone: _____

Pharmacy Name: _____ Address: _____

Name of Emergency Contact: _____ Relationship: _____

Emergency Contact Phone Number: _____

You may leave Insurance section below blank if insurance cards have been provided:

Name of Primary Insurance: _____Policy Number: _____

Policy Subscriber Name: _____ Date of Birth: _____ Effective Date: _____

Name of Secondary Insurance: _____ Policy Number: _____

Policy Subscriber's Name: _____ Subscriber Date of Birth: _____

Patient's relationship to subscriber: Self Spouse Child Social Security Number: _____

The guarantor is the person responsible for the patient's bill. If the patient is responsible for his/her own bill please skip the next section.

Guarantor's last name: _____ Guarantor's first name: _____

Guarantor's mailing address: _____

Guarantor's phone number: _____ Relationship to patient: _____

Guarantor's Date of Birth: _____ Guarantor's social security number: _____

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THIE ORIGINAL. I REQUEST MEDICARE BENEFITS TO BE PAID DIRECTLY TO THE PROVIDER OF SERVICES AS THEY DO NOT ACCEPT ASSIGNMENT UNDER THE MEDICARE PARTICIPATING PHYSICIAN PROGRAM.

PATIENT SIGNATURE_____ DATE_____

I ACKNOWLEDGE FULL RESPONSIBILITY FOR THE PAYMENT OF SERVICES RENDERED TO ME AND AGREE TO PAY FOR SERVICES NOT COVERED BY MY INSURANCE CARRIER. I UNDERSTAND IT IS MY RESPONSIBILITY TO PAY ANY DEDUCTABLE AMOUNT, CO-PAYMENT, COINSURANCE, OR ANY OTHER BALANCE NOT PAID FOR BY INSURANCE. I UNDERSTAND AND AGREE THAT HEALTH INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEM AN INSURANCE CARRIER AND MYSELF. I AUTHORIZE PAYMENT OF MEDICAL/SURGICAL BENEFITS TO THE AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION IN PROCESSING OF INSURANCE.

SIGNATURE OF PATIENT_____ DATE_____

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