Dr.'s S. Majumder & R. Palnitkar
Please Circle the Physician you are seeing
Please Print Clearly and Legible

Patient Information Form

Today's Date: ________________ **Referring/PCP Physician Name** ______________________
First Name Last Name

Patient Information:

Last Name: ___________________ First _______________ Middle __________ Gender: F M

Street Address: _____________________________ City: ______________ State & Zip _________

Date of Birth: ___________________ SS# (Patient) __________________ Home # _____________

Employer: _________________________ Occupation: _______________ Work # _____________

Preferred Pharmacy Name: ______________________ Phone: _________________________
Pharmacy Street ________________________ City ______________________

Marital Status: Sgl / Mar / Div / Sep / Wid Email _______________________

Insurance Information (Please give your Insurance Card(s) to Receptionist

All information must be filled out completely

Person Responsible for Bill: __________________ DOB __________ SS# ________________

Address if Different _________________________ City _________________ State & Zip ________

Relationship to Patient: _______________________

Employer ___________________________ Work # ________________________

Please Indicate **Primary Insurance** ______________________ **2nd Insurance** __________________

The Information Below Must Be Filled Out Completely to Bill Your Secondary Ins.

Note: If Any Of These Questions Are Not Fully Answered, We Will Not Bill Your Secondary Because The Claim Will Be Denied For Incomplete Or Invalid Information.

Subscriber's Name: _______________________ SS# _____________________ DOB ___________

Address _____________________________ City ____________________ State & Zip ___________

Employer ______________________________ Home# _________________ Work# _________________.

Relationship to Patient: Self / Spouse / Child / Other

In Case of Emergency:

Name ______________________ Relationship to Patient _____________ Hm# ________________

Wk# ______________

Last Pneumonia Vaccine: Date___________________________

Last Flu Vaccine: Date___________________________

Professional Services Rendered Are Charged To The Patient. Necessary Forms Will Be Completed To Help Expedite Insurance Payments. However The Patient Is Responsible For All Fees, Regardless Of Insurance Coverage. It Is Also Customary To Pay For Services When Rendered Unless Other Arrangements Have Been Made In Advance With Our Bookkeeper.

Insurance Authorization and Assignment

I Hereby Authorize Dr.'s R. Palnitkar & S. Majumder To Furnish Information To Insurance Carriers Concerning My Illness And Treatments, And I Hereby Assign To The Physician (s) All Payments For Medical Services Rendered To My Dependents or Myself. I Understand That I Am Responsible For Any Amount Not Covered By Insurance.

Date ___/___/___ Signature: ________________________________

I Understand That If My Insurance Company Required Preauthorization and/or Physician Referral for Consults and/or Office Visits, And I Don't Supply Dr.'s R. Palnitkar & S. Majumder With This Preauthorization and/or Referral Then I Will Be Responsible For Paying My Bill.

Date ___/___/___ Signature: ________________________________

I Hereby Authorize Dr.'s R. Palnitkar & S. Majumder To Include Human Immunodeficiency Virus Test Results In Reports To Insurance Carriers.

Date ___/___/___ Signature: ______________________________

Do you have an Advanced Directive

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Do you have a Designated Power of Attorney

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Revised 07/18/11