NEW PATIENT INDENTIFICATION SHEET

Name: _____ Birth date: _____
Last First Middle

Date First Seen: _____Referred By: _____ Race: _____ Sex: _____

Mother's Name: _____SS#_____ Email: _____
Last First Middle
Address: _____ Cell Phone: _____Home: _____
Street City Zip
Mother's Work Number_____ Mother's Employer _____

Father's Name: _____SS#_____E-mail_____
Last First Middle
Address: _____ Cell: _____ Home_____
Street City Zip
Father's Work Number: _____ Father's Employer _____

COMMUNICATION PREFERENCE: _____Text ____ Cell _____ Home _____Email _____ Mail

PREFEERED PHONE NUMBER FOR US TO CONTACT YOU: ____.

Other Children in Family:

Name Last First Birth Date	Name: Last First Birth Date
1._____	4._____
2._____	5._____
3._____	6._____

Person to Call in an Emergency: _____ *Relation*: _____ Phone_____

Guarantor's Name _____ Relationship to patient _____
Insurance Company Name: _____ Effective date_____
Policy Holder Name: _____ Birth date: _____ Relationship to Patient_____
Group No: _____Member ID No: _____ _____ Co-Pay_____

INSURANCE AUTHORIZATION AND ASSIGNMENT: (Please read and sign)
I hereby authorize Dr.Bharani to treat my child/children for any illness in my absence and furnish information to insurance carriers concerning my child's illness and treatments and I hereby assign to the physician all payments for medical services rendered to my dependents.

I understand COPAYMENT AND DEDUCTIBLE ARE DUE AND PAYBALE AT TIME OF SERVICE. It is my responsibility to provide proper insurance Information to this office for staff to file insurance properly. I understand that I am responsible for any amount not covered by insurance. I further permit a copy of this authorization to be used in place of original. I will be paying today by:

Cash_____ Check_____ Charge card_____ Debit card: _____

_____Date:_____
Signature of Parent/Legal Guardian Relationship