Saluja Medical Associates
Patient Registration Form

Patient Information

Name _____ Social Security # _____

Address _____

City _____ State _____ ZIP _____

Please Circle Preferred Contact Phone Number

Home Phone # _____ Cell # _____ Office # _____ ext. _____

Email _____

Sex _____ Male _____ Female Age _____ years DOB _____ / _____ / _____

Place of Employment _____ Occupation _____

Person to contact in case of emergency _____

Relationship to Patient _____ Phone # _____

Insurance Information

Do you have Medical Insurance _____ Yes _____ No

Name of Primary Insurer _____ Group # _____

Subscriber Name _____ Subscriber # _____

Name of Secondary Insurer _____ Group # _____

Subscriber Name _____ Subscriber # _____

____ Medicare _____ Medicaid Claim ID # _____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with the above stated insurer. I assign directly to Saluja Medical Associates all insurance benefits, if any, otherwise payble to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the physician to release all necessary information to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature Relationship Date