

Shridhar Ventrapragada, MD

PERSONAL INFORMATION

Name: _____ (Last) _____ (First) _____ (Middle Initial)
Address: _____ Age: _____ Sex: M F
City: _____ State: _____ Zip Code: _____
Social Security #: _____ Marital Status: _____ DOB: _____
Phone number: _____ Cell Phone: _____
Name of Parent/Guardian: _____
E-mail address: _____
Emergency contact not living with you: _____ Phone #: _____
Requesting Physician Name: _____
Physicians Address and phone number: _____
Pharmacy Name: _____
Pharmacy Address and phone number: _____

INSURANCE INFORMATION

Primary Insurance: _____ Insured's Name _____
Policy # _____ Group # _____
SSN: _____ DOB: _____
Secondary Insurance: _____ Insured's Name _____
Policy # _____ Group # _____
SSN: _____ DOB: _____

NOTICE REGARDING INSURANCE CLAIMS/PAYMENTS:

If we are filing insurance for your visit, we must have complete information and any required referral at the time of the visit. If you cannot provide the information, we will be unable to file your insurance and payment in full will be required. Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment will be based on your individual health plan, and the amount applied to your deductible and/or coinsurance will be your responsibility. Procedures which are excluded from coverage, based on your plan's determination of medical necessity, will also be your responsibility. Your office visit co-pay is due at the time of the visit an, in many cases, covers only the office visit charge. Any procedures performed will be considered surgery by your insurance company, and deductibles and coinsurances may apply. For all other patients, payment is required at the time of service. We will provide you with the necessary documentation to file for reimbursement upon your request.

I have read the above information and understand that I am responsible for payment for services I receive.

Patient/Guardian Signature _____ Date: _____