Pamela Moore, MD Rama Mulupuri, MD Sophia Rahman, MD

Patient's Name:_____ Date of Birth: _____/_____/_____

Gender: ▢ *Female* ▢ *Male* Marital Status: ▢ *Single* ▢ *Married* ▢ *Divorced* ▢ *Widowed* ▢_____

Address/City/Zip: _____

Phone #s: Home_____Cell_____Work_____

Email Address: _____(emails are never shared or sold)

Driver's License #: _____ State Issued: _____

Employer: _____ Occupation: _____

*Race/Ethnicity: _____ *Preferred Language: ▢ English ▢ Other: _____

Preferred Pharmacy:_____ Phone Number:_____ City:_____

Cross Streets/Address:_____

**Medicare Requirement*

Primary Insurance Information

Insured's Name_____ Date of Birth: _____/_____/_____

Relationship to Patient: _____

Insured's Employer: _____

Insurance Carrier: _____ Insurance Co. Phone #: _____

ID #: _____ Group #: _____ HMO POS PPO EPO other (circle one)

Secondary Insurance Information

Insured's Name_____ Date of Birth: _____/_____/_____

Relationship to Patient: _____

Insured's Employer: _____

Insurance Carrier: _____ Insurance Co. Phone #: _____

ID #: _____ Group #: _____ HMO POS PPO EPO other (circle one)

Emergency Contact

Name: _____ Relationship to Patient _____

Address / city / state / zip: _____

Phone #s: Home_____Cell_____Work_____

Who referred you to our office? _____

I hereby authorize my doctor to release any information requested by my Insurance Company, its representative, physician management company, or other physician for medical consultation purposes. I authorize all benefit payments to be made directly to the doctor. All information provided is true and correct to the best of my knowledge.

Patient's Signature: _____ Date:_____