Prema Kothandarman M.D.
The OB/Gyn and Incontinence Center

Please Print ALL information requested below

Last Name _____
First Name _____ M.I _____
Mailing Addr. _____
_____
City_____
State _____ Zip _____
Cell Phone _____
Home Phone _____
Alt. Phone _____
eMail _____
Responsible Party: □ Self □Other
If other, Name _____
Address _____
Phone _____

PCP _____
Referring Physician _____
Date of Birth _____ /_____ / _____
Sex □ Female □ Male
Social Security _____ / _____ / _____
Marital Status □Single □ Married □Separated
Emergency Contact _____
Relationship _____
Address _____
City, State ZIP _____
Cell _____
Alt Phone _____

Race: □American Indian or Alaska Native □Asian □Native Hawaiian or Other Pacific Islander
□Black or African American □White □Hispanic
□Other Race □Other Pacific Islander □Unreported/Refused to Report

Ethnicity: □Hispanic or Latino □Not Hispanic or Latino □Refused to report

Language: □English □Indian (Hindi and all other) □Spanish □Russian □Armenian □Other

Insurance Carrier Name _____ □Primary □Secondary
Member ID _____
Group No _____ Group Name _____
Insured's Name _____ Patient relationship to Insured □Self □Spouse □Child
Insured's DOB _____/_____/_____
Medical # _____ Medicare _____

Insurance Carrier Name _____ □Primary □Secondary
Member ID _____
Group No _____ Group Name _____
Insured's Name _____ Patient relationship to Insured □Self □Spouse □Child
Insured's DOB _____/_____/_____
Medical # _____ Medicare _____

Pharmacy Name _____
Pharmacy Address _____ City _____ State ____ Zip _____
Pharmacy Phone _____ Pharmacy Fax _____

How did you hear about us? □Friend □Insurance □Hospital □Doctor _____
□Yelp □Google □Facebook □Other Internet
□News paper _____