Ranjit S. Grewal, M.D.,PA

21216 Northwest Freeway, Ste.260
Cypress, Texas 77429

Patient Information:

Name:_____
First Middle Last

DOB:_____**SS#**_____**Sex: M / F EMAIL:**_____

Address:_____
Street City State Zip

Cell:_____**Home:**_____**Work:**_____

Race:_____**Ethnicity:**_____**Primary Language:**_____

Pharmacy Name:_____**Pharmacy Phone:**_____

Insurance Information:_____
Insurance Company PO BOX

Member ID:_____**Group#**_____

Policy Holder_____
Name DOB SS#

Secondary Insurance:_____
Insurance Company PO BOX

Member ID:_____**Group#**_____

Emergency Contact:_____**(relation)**_____**Phone:**_____

I authorize the release of Medical Information to:_____

I hereby assign, transfer, and set over to Ranjit S. Grewal, MD, PA all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges wether or not they are covered by insurance.

Patient's Signature_____**Date:**_____