Sujatha Borra MD., PA

Patient Registration Form

Name (First, Middle, Last): _____

Date of Birth: _____ Age: _____ Sex: ◯ Male ◯ Female Social Security Number: _____

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed

Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Insured's Employers Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Is your visit Accident Related? ◯ Yes ◯ No Date of Accident: _____

Describe Accident: _____

Referring Physician: _____ Referring Physician's Phone: _____

Referring Physician's Address: _____

City: _____ State: _____ Zip: _____

Primary Insurance Name: _____

Name of Insured: _____ Employer's (Group) Name: _____

Relationship of Insured to Patient: _____ Date of Birth: _____ Social Security Number: _____

Insurance Identification: _____ Insurance Group #: _____

Address to send Claims: _____

City: _____ State: _____ Zip: _____

Secondary Insurance Name: _____

Name of Insured: _____ Employer's (Group) Name: _____

Relationship of Insured to Patient: _____ Date of Birth: _____ Social Security Number: _____

Insurance Identification: _____ Insurance Group #: _____

Address to send Claims: _____

City: _____ State: _____ Zip: _____

Benefits Assignment:

I hereby authorize the assignment of benefits (payments) directly to Sujatha Borra MD., PA for all insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that CO pays, deductibles and non-covered services are due at the time of service.

Signature of Responsible Party: ---------- Date: ----------

Records Release:

I authorize the release of any medical information necessary for the purpose of processing my claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Signature of Responsible Party: ---------- Date: ----------