Kanuru Interventional Spine & Pain Institute

Insurance Cards Copied: ___/___/___

Patient Registration Form

PERSONAL INFORMATION

Marital Status: ☐ Single ☐ Married ☐ Widow Sex: ☐ Male ☐ Female

Name: _____
Last First Middle Initial

Date of Birth: ___/___/___ SSN: _____ **Email**: _____

Home Phone: (___) ___-_____ Work Phone: (___) ___-_____ Cell: (___) ___-_____

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

Employer: _____

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

Spouses Name: _____
First Last Middle

CARD HOLDERS INFORMATION: (IF OTHER THAN YOURSELF)

Responsible Party: _____ Date of Birth: ___/___/___
First Last M.I.

Relationship to Patient: ☐ Self ☐ Spouse ☐ Other SSN: _____

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

Home Phone: (___) ___-_____ Work Phone: (___) ___-_____ Cell: (___) ___-_____

Employer: _____

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

Is the condition work related? (see attached sheet if yes) Yes **Auto Accident?** (see attached sheet) Yes **Date of Injury:** ___/___/___

PATIENT'S INSURANCE INFORMATION

Primary Insurance Name: _____

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

Insurance ID Number: _____ Group Number: _____

Second Insurance Name: _____

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

Insurance ID Number: Group Number:

PATIENT REFERRAL INFORMATION **(Please complete this information as thoroughly as possible)**

Referred By: _____ **City:** _____ **Phone:** _____
First Name Last Name

Primary Care Physician: _____ **City:** _____ **State:** _____

Phone: _____ **Fax:** _____

Names of other physicians who care for you: _____

EMERGENCY CONTACT INFORMATION

Name of person not living with you: _____ Phone: _____

Relationship to patient: _____ Cell: _____

Assignment of Benefits

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Ramesh P Kanuru, M.D. Inc. D/B/A Kanuru Interventional Spine & Pain Institute, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. If I do not pay the entire balance within 30 days of the statement date, a late charge of 1.5% will be assessed each month. In the event of default, I agree to pay all cost of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.