MANJARI ARAVAMUTHAN, MD

INTERNAL MEDICINE & PRIMARY CARE

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SAN JOSE, CA 95121
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PATIENT INFORMATION

Date: _____

Name: _____ DOB: _____
(Last Name) (First Name) (Middle Initial)

Address: _____

Home Phone: _____ Cell. Phone: _____ E-mail: _____

Sex: Male Female Single/ Married/ Divorced/ Widowed SS #: _____

Patient Employer: _____ Occupation: _____

Employer Address: _____ Tel: _____

Person to be notified in case of emergency: _____ Tel: _____

Whom may we thank for referring you? _____

PRIMARY INSURANCE

Insurance Name: _____ ID#: _____

Person responsible for the account: _____ D.O.B: _____

SECONDARY INSURANCE

Insurance Name: _____ ID#: _____

Person responsible for the account: _____ D.O.B : _____

ASSIGNMENT AND RELEASE

I certify that I , and/ or my dependent(s), have insurance coverage with _____
(INSURANCE NAME)

and assign directly to DR. MANJARI ARAVAMUTHAN all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance**. I hereby authorized the doctor to release all information necessary to secure the payment of benefits. I authorized the use of this signature on all insurance submissions.

_____ _____ _____
(Signature Of Patient or Representative) (Relation to Patient) (Date)