PREM SAHASRANAM, MD
1524 West Lacey Blvd, Suite 201
Hanford, CA 93230

PATIENT INFORMATION SHEET

NAME:____DATE:____________

ADDRESS:_______________________________CITY______________ ZIP CODE_________

REFERRING PHYSICIAN/SOURCE:____

HOME PHONE:_________________WORK PHONE:________________SS#_______________

DATE OF BIRTH:_____________ SEX: M F MARITAL STATUS: M W S D

EMPLOYER:____________________________ADDRESS_____________PHONE ___________

SPOUSE'S NAME:____________________________SPOUSE'S SS#:______________________

SPOUSE'S EMPLOYER:____________________________PHONE:_______________________

NAME OF CLOSEST RELATIVE NOT LIVING WITH YOU:_____________________________

PHONE:___________________

RESPONSIBLE PARTY IF UNDER 18:

NAME :____

ADDRESS:_________________________________CITY:______________STATE:__________

RELATIONSHIP TO PATIENT:____

PRIMARY INS OR INDUSTRIAL CARRIER:____

ID#:_________________________________GROUP #:________________________________

INSURED:___________________________RELATIONSHIP TO PATIENT:________________

SECONDARY INS ____

ID#:__________________________________GROUP#__________________________________

INSURED:___________________________RELATIONSHIP TO PATIENT:________________

I REQUEST THAT PAYMENT UNDER MY INSURANCE PROGRAM BE MADE TO EITHER ME OR ON MY BEHALF TO PREM SAHASRANAM, MD FOR ANY SERVICES FURNISHED TO ME BY THE CLINIC. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY FOR THE PURPOSE OF EVALUATING BENEFITS OR PROCESSING OF A CLAIM.

IN THE EVENT THAT I DO NOT PAY FOR SERVICES PROVIDED BY THIS OFFICE AND THE ACCOUNT IS PLACED FOR COLLECTION, I OR WE UNDERSTAND AND AGREE THAT AN ADDITIONAL AMOUNT EQUAL TO 40% OF THE BALANCE OWING AT THE TIME THE ACCOUNT IS PLACED FOR COLLECTION WILL BE ADDED TO THE CURRENT BALANCE OWING. IN ADDITION TO A COLLECTION FEE OF 40% OF THE BALANCE OWED, I OR WE AGREE TO PAY INTEREST AT THE RATE OF 10% PER ANNUM UNTIL THE AMOUNT OWED IS PAYED IN FULL. I OR WE FURTHER AGREE TO PAY ALL ATTORNEYS FEES AND COURT COSTS NECESSARY TO COLLECT THIS BALANCE. I AGREE TO A $25.00 CHARGE FOR A MISSED APPOINTMENT NOT CANCELLED AT LEAST 24 HOURS IN ADVANCE OF THE DATE OF MY SCHEDULED APPOINTMENT. THIS CHARGE CANNOT BE BILLED TO MY INSURANCE.

____ ________________________
SIGNATURE (PATIENT OR GUARANTOR IF MINOR) DATE