

**B. Rajesh, M.D.**  
*Patient Information*

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex:  Male  Female Marital Status:  Single  Married  Widow  Divorced  Sep.

Social Security Number: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Driver's License Number: \_\_\_\_\_

Address: \_\_\_\_\_ City&State \_\_\_\_\_ Zip: \_\_\_\_\_

Type of Insurance: \_\_\_\_\_ Contract # \_\_\_\_\_

Insurance Subscriber's Employer: \_\_\_\_\_

How long employed: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City&State \_\_\_\_\_ Zip: \_\_\_\_\_

In case of emergency contact(outside of home): \_\_\_\_\_

Work number: \_\_\_\_\_ Home number: \_\_\_\_\_

Spouses name: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Who referred you to this practice: \_\_\_\_\_

*If the patient is a minor (under 18 years old) or a student:*

Parent's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City&State \_\_\_\_\_ Zip: \_\_\_\_\_

Parent's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

How long employed: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City&State \_\_\_\_\_ Zip: \_\_\_\_\_

**AUTHORIZATION:** I hereby authorize any holder of medical information to release any information needed to determine benefits and I hereby irrevocable assign Medicare benefits and/or any other medical benefits to B. Rajesh, M.D. for my medical services rendered.

I understand that I am financially responsible for all charges whether or not covered by my insurance.

Signature - Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_