

Arvin K. Rao, M.D.

Welcome to Our Office  
New Patient Information Sheet

Have you seen Dr. Rao before?: Yes  No  If yes, when: \_\_\_/\_\_\_/\_\_\_ Acct.#: \_\_\_\_\_

Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_ Sex:  M  F Age: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Marital Status:  Single  Married  Widowed  Divorced

Social Security Number of Patient: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Patient's/Parent's Driver's License# \_\_\_\_\_

Patient's Employer: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Ph: ( ) \_\_\_\_\_ Ext.: \_\_\_\_\_ Occupation: \_\_\_\_\_

Cell Ph: ( ) \_\_\_\_\_

Emergency Contact: _____
If related, how related?: _____
Emergency Contact Phone #: _____ - _____ - _____
Spouse/Parent Soc. Sec.#: _____ - _____ - _____
Spouses's Date of Birth: ___/___/___
Spouse's Employer: _____
Spouse's Work Phone: ( ) _____ - _____

List of known drug allergies: \_\_\_\_\_

List of current medications: \_\_\_\_\_

Current Pharmacy: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_ - \_\_\_\_\_

Address or major cross streets of Pharmacy: \_\_\_\_\_

Who is referring you? \_\_\_\_\_ Your primary care doctor? \_\_\_\_\_

Referring doctor's full address: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ St.: \_\_\_\_\_ Zip: \_\_\_\_\_ City: \_\_\_\_\_ St.: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Policyholder SS# \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Policyholder SS# \_\_\_\_\_

Group#: \_\_\_\_\_ Employer Name: \_\_\_\_\_ Group#: \_\_\_\_\_ Employer Name: \_\_\_\_\_

Policyholder: \_\_\_\_\_ Policyholder DOB: \_\_\_\_\_ Policyholder: \_\_\_\_\_ Policyholder DOB: \_\_\_\_\_

PLEASE READ STATEMENT

I authorize release of information necessary to file a claim on my behalf to all insurance carriers. I will allow Dr. Rao to appeal on my behalf any insurance carriers payment of decision.

I consent to the release of information provided to or generated by Dr. Rao to my referring doctor, psychologist, attorney, therapist, agency, or any other party with pertinent interest.

I assign medical benefits otherwise payable to me to Arvin K. Rao, M.D. I understand and agree that I am financially responsible for any unpaid balance for services rendered along with legal fees incurred in collecting payment from me.

Copy of my signature shall be valid as the original.

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_