

PATIENT INFORMATION  
PLEASE PRINT

Last: _____	First: _____	MI: _____	Mr	Mrs	Ms
Mailing Address: _____		City: _____	St: _____		
Zip: _____					
Social Security #: _____	Driver License #: _____				St: _____
Date of Birth _____	Age: _____	Sex: _____	Home Phone _____	Work Phone _____	
Email Address: _____					
Employer: _____					
Employer Address: _____					
Spouse: _____	Employer _____				Work
Phone#: _____					
<b>Emergency Contact:</b>					
Name: _____	Relationship: _____				Phone#: _____

Name of Primary Care Physician? \_\_\_\_\_ Who referred you to this office? \_\_\_\_\_

<b>RESPONSIBLE PARTY/GUARDIAN:</b>					
Last: _____	First: _____	MI: _____	Mr	Mrs	Ms
Mailing Address: _____		City: _____	St: _____		
Zip: _____					
Relationship: _____	Employer _____				Work
Phone#: _____					

*I authorize this medical practice to disclose medical information including medical test results, prescription information, and appointment verification on my voicemail/answering machine or to an immediate family member such as a spouse, parent, child or guardian.*

**YES:** \_\_\_\_\_ **NO:** \_\_\_\_\_  
Initial & Date Initial & Date

**THE RECEPTIONIST WILL MAKE A COPY OF YOUR INSURANCE CARDS**  
You must have available your most current insurance cards at every visit.

*We are required by law to maintain the privacy of your protected health information and to inform you of our legal duties and privacy practices with respect to your protected health information. The notice describing how we may use and disclose this information is available to you upon request.*

**ASSIGNMENT OF INSURANCE BENEFITS:** *I directly assign all medical/surgical benefits to Cynthia S. Bailey, M.D. or Geetinder Chattha, M.D. and understand that I am financially responsible for all fees incurred including copays, deductibles, co-insurance, or any other balances not paid by my insurance regardless of the reason. Questions regarding fees should be addressed before procedures are performed. I hereby authorize the office to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.*

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