New Patient Information Sheet

Santosh K. Garg MD

Speaks English □ Yes □ No – Preferred Language: _____

"**A Professional Medical Corporation**"

Tel: (626) 962-8122 Fax: (626) 962-8408

Patient's Personal Information:

Name: _____ DOB: _____

Street address: _____ City: _____ State: _____ Zip: _____

Home Phone: (___) _____ Patients Gender: □ Male □ Female Social Security #___-___-____

E-Mail Address: _____ Ethnicity: □ Hispanic □ Non-Hispanic □ Unknown

Race: □ White □ Black □ Native American/Eskimo □ Asian/Pacific Islander □ Other _____

Patient/Responsible Party Information

Responsible party: _____ DOB _____

Relationship to Patient: □ Self □ Spouse □ Child □ Other _____ Social Security # _____-____-_____

Responsible party's home phone: (_____) _____ Work phone: (_____) _____

Address: _____ City: _____ State: _____ Zip: _____

Employer's name: _____ Phone #: (____) _____

Your occupation: _____

Patient's Insurance Information

Name of Insured: _____ DOB: _____

PRIMARY insurance company's name _____ Relation to insured: _____

Insurance address: _____ City: _____ State: _____ Zip: _____

Primary insurance ID #: _____ Group #: _____

Emergency Contact

Name of person not living with you: _____ Relationship: _____

Home phone #: (_____) _____ Work phone # (_____) _____

Assignment of Benefits (Financial Agreement)

I hereby give authorization for payment of insurance benefits to be made directly to Santosh K. Garg MD "A.P.M.C", and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Authorization of Treatment

I hereby authorize Santosh K. Garg MD "A.P.M.C" or an associate to render diagnosis and treatment (including lab and X-ray) for myself or my dependent at his office, other facility, or hospital, as necessary for proper management of the patient's medical care.

Release of Information

I further authorize Santosh K. Garg MD "A.P.M.C" to release medical/social information to persons or agencies directly concerned with and engaged in carrying out a treatment plan for the patient. Also, Santosh K. Garg MD "A.P.M.C" may use and release any part of my record necessary for the process of billing third party payers for services rendered in my behalf.

All HMO patients must pay co-payments at the time of service.

Date: _____ **Signature:** _____

Relationship to patient: □ Self □ Other _____