R[illegible]CONDA INTERNAL MEDICINE

JAGDISH LAL, M.D. (BOARD CERTIFIED)

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Welcome

Thank you for selecting our healthcare team! We will strive to provide you with the best possible healthcare. To help meet all your healthcare needs, please fill out this form completely in ink (please print). If you have any questions or need assistance, please ask us, we will be happy to help.

Personal Information: **Date:** _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Birthdate: ____ / ____ / ____

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Phone Numbers: _____ Home _____ Work _____ CELL PHONE

Social Security Number: ____ / ____ / ____

Employer: _____ Job: _____

Employer Address: _____

In the event of an emergency, who should we contact? Name: _____

Relationship: _____ Home Phone No. _____ Work Phone No. _____

Responsible Party: Who is responsible for the account?

Name: _____

Relationship to Patient: _____

Birthdate: ____ / ____ / ____ Driver's License No: _____

Social Security Number: ____ / ____ / ____

Address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____ Occupation: _____

Phone Numbers: _____ Home _____ Work _____ Car

Insurance Information:

Primary Insurance	Additional Insurance
Name of Insurance Co.	Name of Insurance Co.
Policy #	Policy #
Effective Date: / /	Effective Date:
Expiration Date: / /	Expiration Date:
Name of Insured:	Name of Insured:
Insured Address:	Insured Address:
City St. Zip	City St. Zip
Insured's Phone No.	Insured's Phone No.
Insured DOB: / /	Insured DOB: / /
Insured Social Security No.: / /	Insured Social Security No.: / /
Relation to Patient:	Relation to Patient:
Employer:	Employer:
Date of Employment: / /	Date of Employment: / /
Occupation:	Occupation:

Authorization for Payment and Release of Information:

I hereby authorize the release of any information, including the diagnosis and the records of any treatment(s) and/o examinations rendered to me and/or my child during the period of such care to third party payors or other practitioners

I hereby authorize and request that my insurance company pay directly to the doctor or doctor's group any medical and/or surgical insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for service. I agree to be responsible to payment of all services rendered on my behalf or my dependants.

Signature: _____ (SEAL) Date: / /