PATIENT REGISTRATION
(PLEASE PRINT)

PATIENT'S NAME:_____AGE____BIRTHDATE_____
LAST FIRST MIDDLE

PATIENT'S ADDRESS _____
STREET CITY, STATE ZIP CODE
HOME PHONE_____WORK PHONE_____ CELL _____

MALE____FEMALE____RACE_____MARITAL STATUS: _____PREFERRED LANGUAGE_____

EMPLOYER_____SOCIAL SECURITY NUMBER_____

SPOUSE'S NAME_____EMPLOYED BY_____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____POLICY NUMBER _____

GROUP NUMBER_____CARDHOLDER_____DOB_____

INSURANCE ADDRESS_____
STREET CITY, STATE ZIP CODE

SECONDARY INSURANCE: _____POLICY NUMBER _____

GROUP NUMBER_____CARDHOLDER_____DOB_____

INSURANCE ADDRESS _____
STREET CITY, STATE ZIP CODE

I REQUEST THE PAYMENT OF AUTHORIZED INSURANCE BENEFITS BE MADE ON BEHALF TO
T. T. CHANNAPATI, MD. _____SIGNATURE _____DATE

The Department of Health and Human Services has established a "privacy rule" (HIPPA) to help insure that personal health information is protected for privacy. As our patient we want you to know that we will comply fully with the Privacy Rule, and strive to always protect your privacy. When it is appropriate and necessary, we will provide the minimum necessary information to only those we fell are in need of your health care information about treatment, payment, or health care operations, in order to provide health care that is in your best interest. Our complete privacy policies are available for your review in our Examination rooms, and also upon request from our front desk receptionist.

SIGNED _____DATE_____