Date: ______________

Patient Demographic Information

Name: _________________________________ Social Security Number ____________________________
Last, First Name MI

Address: _______________________________ City, State, Zip: _________________________________

Home Phone # (___)____________ Sex ___ M ___ F D.O.B. __________ Martial Status: _________

Employer: ___________________________________ Occupation: ______________________________

Business Address: ____________________________ Work Phone # ____________________________

Emergency Contact: ____________________________ Phone # _________________________________

PRIMARY / ADDITIONAL INSURANCE

Insurance Company: _________________Group # _______________ Subscriber #______________________

Insured ____ Date Of Birth: ________________________
Last Name First Name MI

Relationship to Patient: ____________________________ Social Security # __________________________

Address (if different from patient's) ____

City, State, Zip: __________________________________ Phone Number: (____)____________________

Insured Employed By: ____

Business Address: ____

City, State, Zip: _________________________________ Phone Number: (____)___________________

Is the patient covered by an additional insurance? _____ Yes _____ No

Insurance Company: ____

Group # ____________________________________ Subscriber # ________________________________

Insured: _____________________________________ Date Of Birth: ________________________________

Relation to Patient: ____________________________ Social Security # _____________________________

Address (If different from Patient's) ____

City, State, Zip _______________________________ Phone Number: (____)________________________

Insured Employed by: ___________________________ Business Address: ____________________________

City, State, Zip: _______________________________ Phone Number: (____)________________________

ASSIGNMENT AND RELEASE

I, the undersigned, do hereby authorize Dr. Balasubramanian to release to (Insurance Company) ___________________________
In addition, all medical information, of whatever nature, now in their possession or later required, from whatever source, which pertains or relates to my medical care. This authorization and consent is granted for the sole and limited purpose of facilitating the quality assurance and quality improvement activities conducted by the health plan. I understand and agree that by consenting to and granting this authorization, I am releasing those rights and claims of confidentiality and privilege concerning the information described which may otherwise exit, when used for the purpose described. I further understand and agree that I may withdraw my authorization and consent at any time by written notice of withdrawal to the health plan, provided however, that any such withdrawal will not affect any information disclosed prior to receipt by the health plan of the written notice of withdrawal.

Signature:______________________________ Date: ___________________________