Chitra Venkatraman, M.D., P.A. – Hematology/Oncology
PATIENT REGISTRATION

PATIENT/RESPONSIBLE PARTY INFORMATION

Welcome to our office. In order to serve you properly we will need the following information. (Please Print)
All information will be strictly confidential

Patient Full Legal Name:	Sex: M [ ] F [ ]	Birth Date: ____/____/____ Age _____	Marital Status Single [ ] Married [ ] Widowed [ ] Divorced [ ]
Patient Address, City, State, Zip:		Home Phone:	Patient's SS#:
Person financially responsible for this account (name):	Self [ ] Spouse [ ] Parent [ ]	Responsible Party's D.O.B.:____/ ____/ ____	Responsible Party's SS#:
Responsible Party Driver's License State Number:		Home Phone:	Cell Phone:
Patient Driver's License State Number:		E-mail:	Cell Phone:
Patient's employer/School: Address:		Business Phone:	Occupation: Work/Student status: FT/PT

Reason for Visit:	Whom should we thank for referring you to our practice?

Person to contact in case of emergency:	Relationship to patient:	Phone:
Person to disclose medical condition with:	Relationship to patient:	Phone:

INSURANCE INFORMATION

Medicare? Yes [ ] No [ ]	Medicare #:	Medicaid? Yes [ ] No [ ]	Medicaid #: Issuing State:	Effective Date:

Medicare Secondary Insurance name	Address:	Policy #:	Group #:

Workers' Compensation? Yes[ ] No[ ] Motor Vehicle? Yes[ ] No[ ] **If Yes-put W/C or MVA carrier below**	Date of Accident	Treatment authorized by	Claim #	W/C or MVA Insurance Phone #:

Primary Insurance company: Address:	Is Insurance through your employer? Yes [ ] No [ ]

Subscriber Name:	Subscriber DOB: ___/ ___/ ___	Policy #:	Group #:

Secondary Insurance Company:	Address:	Policy #:	Group #:

SIGNATURE ON FILE

Medicare Lifetime Signature on File:
I request that payment of authorized Medicare benefits be made on my behalf of Chitra Venkatraman, M.D., P.A. for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

_____ _____
Patient Signature Date

Private Insurance Authorization for Assignment of Benefits/Information Release: I the undersigned authorize payment of medical benefits to Chitra Venkatraman, M.D., P.A. for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning healthcare, advice, treatment or supplies provide to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_____ _____
Patient, Parent or Guardian Signature (if child is under 18 years old) Date