

Social Security Number:

Rama Jager, MD, PhD

Last Name:

Shekar Narayanan, MD

First Name: **M.I.**

Arun Gowdamarajan, MD

Nick Name **Sex: F M** **Age:** **Date of Birth:**

Address: _____

Zip: _____ City: _____ State: _____

Driver License Number: _____

Email Address: _____

Note to patient: Primary, Secondary and Cell phone numbers are used by this office to contact and/or to leave messages.

Primary Phone: - - Ext:

Is this number: Home Work Cell Other: _____

Secondary Phone: - - Ext:

Is this number: Home Work Cell Other: _____

Other Phone: - - Ext:

Is this number: Home Work Cell Other: _____

If minor, list guardian (parent): _____

Address: _____

Zip: _____ City: _____ State: _____

Home Phone: _____

Name of primary physician involved in your care:

Last Name: _____ First: _____

Address: _____

City: _____ State: _____ Phone: _____

Marital status:

Single 1 Married 2 Divorced 5 Widowed 4 Other 3

Alternative contact name (Not Spouse): _____

Address: _____

Zip: _____ City: _____

State: _____ Phone: _____

To whom may we release information?

Spouse Patient Your voice mail Other

Patient's employer: _____

Address: _____

Zip: _____ City: _____

State: _____ Phone: _____

Spouse employer: _____

Address: _____

MD Requesting Consultation: _____

(first name) (last name)

Address: _____

Insurance Information *If other than patient, please complete every line, or we may be unable to file claims with your insurance for you*

Primary Insurance Co. Name: _____

Address: _____

Zip: _____ City: _____ State: _____

Phone: () _____

Subscriber Name (If other than self): _____

Sex F M Date of Birth: _____

Subscriber's Social Security Number: _____

Relationship to Patient: Self Spouse Parent

Subscriber's employ _____

Address: _____

Zip: _____ City: _____ State: _____

Phone: () _____

Policy #: _____

Group #: _____

Plan #: _____

Secondary Insurance Company Name:

Address: _____

Zip: _____ City: _____ State: _____

Phone: () _____

Subscriber Name (If other than self): _____

Sex F M Date of Birth: _____

Subscriber Social Security Number: _____

Relationship to Patient: Self Spouse Parent

Subscriber's employer: _____

Address: _____

Zip: _____ City: _____ State: _____

Phone: () _____

Policy #: _____

Group #: _____

Plan #: _____

Do you have a third insurance company? Yes/ No

Company Name: _____

How did you hear about us?

Hemorrhoid Center Plus Ad

Insurance Provider book Billboard Yellow Pages

Friend/Relative Doctor TV Other



1) I understand that I must give a minimum of 48 hours notification before canceling or rescheduling any appointments. 2) I understand that as a courtesy to me, my care will be billed to my insurance carrier. Any charges not covered by my carrier will be my responsibility. 3) If insurance benefits are mailed to me, I agree to forward them directly to you along with the explanation of benefits. 4) Interest will be charged on any balance after 90 days. 5) If after reasonable notice of any balance due on my account, payment is not made, I will be responsible for collection effort fees including attorney and court costs. 6) I authorize Release of any Medical Information Necessary to Process this Claim. 7) I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER. I HAVE RECEIVED A COPY OF THE COLON AND RECTAL CARE PRIVACY NOTICE. I acknowledge that I have received the Colon and Rectal Care Privacy Notice.

Signature: _____

Date: _____