Vishal Gandotra M.D. INC

Patient Registration

Patient Name:_____Date of Birth:___/___/____
Social Security Number:____/____/____ Sex:M/F
Marital Status:_____ Email Address:_____
Address:_____
(street) city/state/zip
Home Phone:(____)_____-_____Cell Phone:(____)_____-_____
Employer:_____Work phone:(____)_____-___
Emergency Contact:_____Phone Number:(___)___-___
Who referred you to our office?_____

INSURANCE/BILLING INFORMATION
PRIMARY

Insurance Company:_____Name of Insured:_____
Address of Insurance:_____Phone Number:(___)___-__
Policy or ID Number:_____Group Name or Number:____
Relationship of the insured to the patient:_____
Insured Date of Birth:_____/_____/_____

INSURANCE/BILLING INFORMATION
SECONDARY

Insurance Company:_____Name of Insured:_____
Address of Insurance:_____Phone Number:(___)___-__
Policy or ID Number:_____Group Name or Number:____
Relationship of the insured to the patient:_____
Insured Date of Birth:_____/_____/_____

ASSIGNMENT INSURANCE BENEFITS

I hereby authorize direct payment of medical/surgical benefits to Dr. Vishal Gandotra for services rendered by him in person or under his supervision. I understand that I am financially Responsible for any balance not covered by my insurance.

Patient Name(PRINT)_____**Date:**___/____/_____
Guardian Name (PRIN)_____**Date:**___/____/_____

Vishal Gandotra M.D. INC
5701 W. Charleston Blvd Ste.207
Las Vegas, Nv. 89146

Patient Name:_____

I hereby agree to be financially responsible for all charges incurred regardless of insurance coverage. In the event my account is referred to a collection service due to lack of payment on my part, I agree that all collection/legal fees may be added to my account.

Returned checks: A $25.00 NSF fee will be charged for checks initially returned to the bank. If the check is returned unpaid a second time, it may be referred to a collection agency for recovery.

_____ _____
Patient signature or responsible Party Date

_____ _____
Signature of witness Date