SHYAM K. NAIR, M.D., FACC

INTAKE INFORMATION

Thank you for choosing our office. In order to assist you please provide us with the following information. All information will be strictly confidential

CONTACT INFORMATION

PATIENT NAME: _____ BIRTH DATE: _____ SEX: MALE / FEMALE (Circle One)

_____ DRIVER LICENSE: _____

HOME PHONE: _____ CELL: _____

EMAIL ADDRESS: _____ ALT. NO: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

REFERRED BY: _____ PHONE: _____

MARITAL STATUS: SINGLE / MARRIED / PARTNER / DIVORCED / WIDOWED / SEPARATED (Please Circle One)

NAME OF EMPLOYER: _____ OCCUPATION: _____ PHONE: _____

EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SPOUSE NAME: _____ OCCUPATION: _____ PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT, COMPLETE BELOW.

NAME: _____ PHONE: _____

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SOCIAL SECURITY: _____ EMPLOYER: _____

INSURANCE INFORMATION

PRIMARY CARRIER: _____ PHONE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

POLICY NUMBER: _____ GROUP NUMBER: _____ CO-PAY _____

INSURED NAME: _____ RELATION: _____ SSN: _____

SECONDARY CARRIER: _____ PHONE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

POLICY NUMBER: _____ GROUP NUMBER: _____ CO-PAY _____

INSURED NAME: _____ RELATION: _____ SSN: _____

As patient, or as legal guardian of minor patient, I agree to pay for all services rendered. This office may bill my insurance carrier as needed.
ASSIGNMENT & RELEASE: I hereby assign my insurance benefits to be paid directly to SHYAM K. NAIR / W.C.M.C. I am financially responsible for non-covered services. I authorize the physicians to release any information necessary to process this request.

SIGNED: _____ DATED: _____

DEMOGRAPHICS

ETHNICITY: NON-HISPANIC / HISPANIC / NOT-SPECIFIED (Please Circle One)

LANGUAGE: _____ (Please Write Language of Preference)

RACE: (Please select one of the following)

[ ] AFRICAN / AFRICAN AMERICAN
[ ] ASIAN / ASIAN AMERICAN
[ ] CAUCASIAN / EUROPEAN AMERICAN
[ ] NATIVE AMERICAN / NATIVE ALASKAN
[ ] NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER
[ ] OTHER RACE

I HEREBY AUTHORIZE DR. SHYAM K. NAIR / W.C.M.C., TO RELEASE ALL MEDICAL INFORMATION TO THE ABOVE NAMED INSURANCE CARRIER OR TO A DESIGNATED ATTORNEY, FOR PURPOSE OF CLAIMS ADMINISTRATION AND EVALUATION, UTILIZATION REVIEW, AND FINANCIAL AUDIT. THIS AUTHORIZATION REMAINS VALID AND EFFECTIVE FROM THE DATE OF SIGNING UNTIL REVOKED IN WRITING. I UNDERSTAND THAT I MAY REQUEST A COPY OF THIS AUTHORIZATION; I READ THIS AUTHORIZATION AND UNDERSTAND IT. I HEREBY ASSIGN TO DR. SHYAM K. NAIR / W.C.M.C. ALL MONEY TO WHICH I AM ENTITLED FOR MEDICAL AND/OR SURGICAL EXPENSE RELATIVE TO THE SERVICE RENDERED BY HIM; BUT NOT TO EXCEED MY INDEBTEDNESS TO SAID PHYSICIAN AND/OR SURGEON. IT IS UNDERSTOOD THAT ANY MONEY RECEIVED FROM THE ABOVE NAMED INSURANCE COMPANY, OVER AND ABOVE MY INDEBTEDNESS WILL BE REFUNDED TO ME WHEN MY BILL IS PAID IN FULL. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE TO SAID DOCTOR(S) FOR CHARGES NOT COVERED BY THIS ASSIGNMENT. I FURTHER AGREE IN THE EVENT OF NON-PAYMENT, TO BEAR THE COST OF COLLECTIONS, AND/OR COURT COST AND REASONABLE LEGAL FEES SHOULD THIS BE REQUIRED.

INSURED/GUARDIAN SIGNATURE: _____ DATE: _____

PATIENT SIGNATURE: _____ DATE: _____