

Patient Registration Information

Purushotham Kotha, M.D. FACC

Patient's Personal Information

Name: _____
Last Name First Name Middle Initial

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) ____ - ____ Work Phone: (____) ____ - ____

Cell Phone: (____) ____ - ____ Age: _____

Social Security #: _____ - _____ - _____ Date of Birth: ____/____/____

Allergies: _____

Spouse's Name: _____
Last Name First Name Middle Initial

Spouse's Social Security #: _____ - _____ - _____

Patient's Insurance Information

Do we have a copy of insurance cards? YES NO

Primary insurance company's name:

Primary Insurance ID #: _____

Secondary Insurance Company Name:

Secondary Insurance ID #: _____

Patient Referral Information

Referred by: _____

Name(s) of other physicians that care for you: _____

Emergency Contact

Name of person not living with you: _____

Relationship: _____ Home Phone #: (____) ____ - ____

Work Phone #: (____) ____ - ____ Cell Phone #: (____) ____ - ____

I hereby give lifetime authorization for payment of insurance benefits to be made directly to PURUSHOTHAM KOTHA, M.D., and assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature: _____ Date: _____