

# 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: \_\_\_\_\_