

New Braunfels OB/GYN

Pharmacy & Location: _____

Primary Physician: _____

PATIENT REGISTRATION INFORMATION

PLEASE FILL IN ALL QUESTIONS AND PRINT CLEARLY:

Patient's Social Security: _____ Date of Birth: _____ Today's Date: _____

Patient's Name: _____ Main Phone: _____ Wk/Cell Phone: _____

Address: _____
CITY STATE ZIP CODE

If Minor - Parent/Guardian: _____ Contact Phone: () _____

Relation to Patient: _____

Other Address (Mailing) If Different Than Above:
Address: _____
CITY STATE ZIP CODE

Marital Status: Single Married Divorced Widowed

Race: African American Asian Hispanic White Other Race

Ethnic Group: Hispanic Non-Hispanic

Referred By: _____ Patient Email: _____

Patient's Employer: _____ Department: _____

Employer's _____

Phone: () _____

Spouse's Name: _____ Spouse's Contact ph #: _____

Spouse's Employer: _____ Department: _____

Person To Contact In Case Of Emergency (Other than spouse): _____

Address: _____

Relation: _____ Phone: () _____

INSURANCE INFORMATION

Insurance Coverage YES NO Medicaid Medicare

PRIMARY COVERAGE

Insured: _____

Self Spouse Other/Relation: _____ Insured

Name of Insured: _____ Date of Birth: _____ SS#: _____

Insurance Name: _____ Policy #/ID#: _____

Relation to Insured: Self Spouse Child Group #: _____

Claim Address/Ph #: _____

SECONDARY COVERAGE

Insured: _____

Self Spouse Other/Relation: _____ Insured

Name of Insured: _____ Date of Birth: _____ SS#: _____

Insurance Name: _____ Policy #/ID#: _____

Relation to Insured: Self Spouse Child Group #: _____

Claim Address/Ph#: _____

WE WILL ASK TO MAKE A COPY OF YOUR INSURANCE CARD(S) AND A PHOTO ID FOR OUR FILES

PATIENT INFORMATION FORM

**ALL PROFESSIONAL FEES ARE DUE AT THE TIME OF SERVICE, UNLESS PREVIOUS
ARRANGEMENTS HAVE BEEN MADE.**

FINANCIAL AGREEMENT

- 1) **Services are rendered to the patient, not the insurance company. As a courtesy, our office will file your insurance if proper information is received.**
 - A) **You are responsible for co-pays, deductibles, non-covered services, co-insurance and items considered "not medically necessary" by your insurance company.**
 - B) **For unpaid claims over 45 days, it is your responsibility to follow up with your insurance and the balance due is considered due and payable.**
- 2) **It is your responsibility to notify our front desk staff of any insurance or address changes.**
- 3) **You will be responsible for any charges that occur if we are not notified.**

PATIENT AUTHORIZATION

I authorize **Nagakrishna Reddy M.D.** to submit insurance claims using my signature on file below.

I authorize the release of any medical information necessary in order to process this assignment on the claim.

I authorize payment of medical benefits to be paid directly to **Nagakrishna Reddy M.D.** for services described on the claim form.

Patient Signature (Parent or Authorized Representative)

(Date)

Your Special Comments/Instructions to Us:

