

PERSONAL INFORMATION:

NAME: _____ CHART# _____
 First Middle Last

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

E-MAIL ADDRESS: _____

SOCIAL SECURITY #: _____ BIRTH DATE: _____ AGE: _____

MARITAL STATUS: M S D GENDER: M F HOME PHONE: _____
 Please circle one Please circle one CELL PHONE: _____

OCCUPATION: _____ WORK PHONE: _____

COMPANY: _____

IF WORKMAN'S COMP INJURY, EMPLOYER CONTACT: _____

DATE OF INJURY: _____

EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP: _____
 First Last

HOME PHONE: _____ WORK PHONE: _____

REASON FOR VISIT: _____

REFERRED BY: _____

SIGNATURE: _____ DATE: _____

RELEASE OF INFORMATION FOR INSURANCE PAYMENT:

I hereby authorize Sanjay K. Sharma M. D. to release any medical or other information necessary to process and pay my medical claims.

SIGNATURE: _____ DATE: _____

ASSIGNMENT OF BENEFITS FOR INSURANCE PAYMENT:

I assign payment to Sanjay K. Sharma M. D. for all medical services rendered by him and his staff.

SIGNATURE: _____ DATE: _____

AUTHORIZATION OF MEDICAL CARE:

I hereby authorize Dr. Sanjay Sharma to instruct Gina Jones, LVN, to assist him in certain aspects of my medical care. I understand that a Licensed Vocational Nurse is not a licensed physician and may not treat or diagnose any illness, injury, or medical condition except under the supervision and direction of a licensed physician. I further understand that I may revoke this authorization at any time and that, at any time, I may request to be seen by Dr. Sharma.

SIGNATURE: _____ DATE: _____