

**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: \_\_\_\_\_