

B. S. Chandrasekhar, M.D., F.A.C.S.

Registration Form

Thank you for choosing our office! In order to serve you properly, PLEASE PRINT the following information.

PATIENT INFORMATION

Legal Last Name	First	MI	AKA Name	Patient ID - Office Use Only	
Social Security	Sex M F	Birth Date / /	Marital Status S M W D	Driver's License	
Residence Street Address	Apt	City	State	Zip	
Day Phone	Evening Phone	Cell Phone	Contact Preference		
Employer's Name	Address	City	State	Zip	Occupation
Race	Religious Preference	Place of Birth	Email		
Referral Source (please give specific name)					

PERSON TO CONTACT IN CASE OF EMERGENCY

Last Name	First	MI	Relationship		
Residence Street Address	City	State	Zip	Home Phone	Business Phone
Nearest Relative or Friend not living with you	Last Name	First Name	MI	Relationship	
Residence Street Address	City	State	Zip	Home Phone	Business Phone

GUARANTOR (PERSON WHO GUARANTEES FINANCIAL OBLIGATION)

Last Name	First	MI	Relationship	Social Security	Driver's Lic No
Residence Street Address	City	State	Zip	Evening Phone	
Employer's Name	Address	City	State/Zip	Work Phone	Occupation

INSURANCE INFORMATION (if applicable)

PRIMARY INSURANCE	Subscriber's Name	Relationship	Subscriber's Address (if different than pt.)	
Subscriber's SSN	Subscriber's DOB	Employer Name & Address		Employer's Phone
Insurance Company Name	Policy/Cert/Medicare #		Plan	Group Number
SECONDARY INSURANCE	Subscriber's Name	Relationship	Subscriber's Address (if different than pt.)	
Subscriber's SSN	Subscriber's DOB	Employer Name & Address		Employer's Phone
Insurance Company Name	Policy/Cert/Medicare #		Plan	Group Number

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Chandrasekhar to bill my insurance company - if applicable. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between B. S. Chandrasekhar, M.D., Inc. and myself.

Signature of Patient/Insured

Date