KATY
Pain and Spine

☐ **Karan Madan, MD.** ☐ **Nimish Davé, MD.**
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NEW PATIENT INFORMATION FORM

Last Name: _____ First Name: _____ MI: _____

Address: _____ City/State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

SSN: _____ Date of Birth: _____ Male ___ Female ___

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Referring Physician: _____ Primary Care Physician: _____

Marital Status: Married ___ Divorced ___ Widowed ___ Single ___ Separated ___

Spouse's Name: _____ Date of Birth: _____

Spouse Employer: _____ Employer Phone: _____

_____ _____
Primary Insurance Carrier | Subscriber Name / DOB / SSN

_____ _____
Insurance ID # | Insurance Group #

_____ _____
Secondary Insurance Carrier | Subscriber Name / DOB / SSN

_____ _____
Insurance ID # | Insurance Group #

Note: We will bill your secondary insurance as a courtesy. If claims are not paid within 60 days the balance will be transferred to the patient responsibility.

Is your condition the result of a work related injury? _____ Date of Injury: _____
Is your condition the result of a MVA or any other accident? _____ Date of Injury: _____

My signature below indicates that I have been given the chance to read and review the following and understand and agree to their terms:

*Financial Policy, Consent for Treatment, and Release of Medical Information Form (see page 3)
*Notice of Privacy Practices at my discretion (located at front desk).

I agree that the above information is true and I authorize this information to be used to obtain financial reimbursement. Additionally, I authorize my attending physician to administer treatment and perform procedures as may be deemed necessary or advisable in my diagnosis. I further authorize the release of any medical information necessary to process my insurance claim and request payment of medical services to be assigned directly to my attending physician. In the event my insurance does not cover services rendered, I agree to be personally and fully responsible for payment. This authorization is to remain in full force unless I revoke the same in writing.

Patient's Signature: _____ Date: _____

Reviewed by: _____ Date: _____