

Insurance Information for Patients

Name of Patient _____

Date _____

Primary Insurance

Name of Insured: _____ Date of Birth _____

Social Security # _____ - _____ - _____ Group # _____

Employer: _____

Employer's address: _____

Relationship to Patient (please circle) self child spouse

Name of Insurance Company: _____

Address: _____ Telephone# _____

Secondary Insurance

Name of Insured: _____ Date of Birth _____

Social Security # _____ - _____ - _____ Group # _____

Employer: _____

Employer's address: _____

Relationship to Patient (please circle) self child spouse

Name of Insurance Company: _____

Address: _____ Telephone# _____

Insurance Authorization

I hereby authorize Sabrina A. Lahiri, MD to furnish all necessary information including photographs to process my claim(s) for service(s) rendered from this date forward and concerning my illness and treatment to all of my insurance carriers. Also, I consent to this consultation and treatment and further consent to the release of my medical records upon request.

Patient Signature _____

Date _____

Insurance Assignment

I hereby authorize payment of all medical benefits rendered to myself or my dependants to Sabrina A. Lahiri, MD and understand that I am responsible for all remaining balances not covered by my insurance carrier. A copy of this signed authorization can be accepted as an original.

Patient Signature _____

Date _____