CLARKSVILLE PULMONARY AND CRITICAL CARE
JATIN K. KADAKIA, M.D., F.C.C.P.
311 LANDRUM PLACE, STE # 700
CLARKSVILLE, TN 37043

DATE: _____

PATIENT INFORMATION

PHONE (___) _____ - _____ CELL (___) _____ - _____ DATE OF BIRTH ___/___/___

NAME _____ SSN ___-___-____
LAST NAME FIRST NAME MI

ADDRESS _____

CITY _____ STATE _____ ZIP _____

SEX (circle one) MALE FEMALE

MARITAL STATUS (circle one) SINGLE MARRIED WIDOWED SEPARATED DIVORCED

EMPLOYER _____ JOB TITLE _____

EMPLOYER PHONE (___) _____ - _____ EMPLOYER ADDRESS _____

CITY _____ STATE _____ ZIP _____

WHOM MAY WE THANK FOR REFERRING YOU TODAY? _____

EMERGENCY CONTACT _____ RELATIONSHIP _____

CONTACT NUMBER (___) _____ - _____ E-mail: _____

PRIMARY INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT _____
LAST NAME FIRSTNAME MI

RELATIONSIP TO PATIENT _____ DATE OF BIRTH ___/___/___ SSN ___-___-____

ADDRESS (if different from above) _____

CITY _____ STATE _____ ZIP _____

PERSON RESPONSIBLE EMPLOYER (if different from above) _____

JOB TITLE _____

EMPLOYER ADDRESS (if different from above) _____

CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____

CONTRACT # _____ GROUP # _____ SUBSCRIBER # _____

NAME OTHER DEPENDENTS COVERED BY THIS PLAN _____

ADDITIONAL INSURANCE

IS PATIENT COVERED BY ADDITIONAL INSURANCE? (circle one) YES NO

SUBSCRIBER NAME RELATIONSHIP TO PATIENT_____ DATE OF BIRTH ___/___/____

ADDRESS (if different from above) _____

CITY _____ STATE _____ ZIP _____

SUBSCRIBER EMPLOYER _____ EMPLOYER PHONE (___) _____

_____

INSURANCE COMPANY _____

CONTRACT # _____ GROUP # _____ SUBSCRIBER # _____

NAME OTHER DEPENDENTS COVERED BY THIS PLAN _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Jatin Kadakia all insurance benefits, if any , otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

RESPONSIBLE PARTY SIGNATURE RELATIONSHIP DATE