

Date	DOB	Sex	Group ID	Internal Use			
Patient Information							
Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #
Address			Home:	How did you hear of us?			
Address 2			Work:				
			Cell:				
			Email:				
City	State	Zip Code	Employer Name & Address			Occupation	
Emergency Contact		Phone	Pharmacy			Pharmacy Phone	

Physician	Family Physician	Referring Physician
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Medical Insurance	Name & Address	Policyholder	Relationship	Policy ID	Group ID
1					
2					
3					

Guarantor (Person to be billed, if different than patient)							
1 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #	
Address			Home:	Work:	Email:		
City	State	Zip Code	Employer Name & Address			Occupation	
2. Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #	
Address			Home:	Work:	Email:		
City	State	Zip Code	Employer Name & Address			Occupation	

HIPAA Approved Contacts							
1. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship	
Address		City	State	Zip Code	Home:	Cell:	Work:
2. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship	
Address		City	State	Zip Code	Home:	Cell:	Work:

Patient's or Authorized Person's Signature			
<p>I the undersigned give my authorization to treat and assign directly to K Kantu, MD , all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.</p> <p>I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.</p>			
Signature	Signature Date	K Kantu, MD 2204 Voochies Avenue Brooklyn, NY 11235	
X		Phone: 718-646-2500	Email:
Please attach all pertinent insurance ID cards for photocopying.			