LENOX MEDICAL CLINIC

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Sudha Challa, MD

Patient Registration Form

Please complete all sections accurately. This information is required to provide safe, high-quality care and to process your insurance or billing.

PATIENT INFORMATION

Legal Last Name: _____ Legal First Name: _____ Middle Name: _____

Suffix (Jr./Sr./etc.): _____Date of Birth: _____Sex Assigned at Birth: ☐ M ☐ F

Driver's License Number: _____ Driver's License State: _____

Race: _____Ethnicity: ☐ Hispanic ☐ Non-HispanicMarital Status: _____

Preferred Language: _____Preferred Contact: ☐ Phone ☐ Text ☐ Email

CONTACT INFORMATION

Mailing Address: _____

City: _____ State: _____ ZIP Code: _____

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

Email Address: _____

EMPLOYMENT INFORMATION

Employment Status: _____ Employer Name: _____ Employer Phone: _____

Occupation: _____ Employer Address: _____

City: _____ State: _____ ZIP Code: _____

PHARMACY INFORMATION

Preferred Pharmacy Name: _____ Preferred Pharmacy Address: _____

Phone: _____

INSURANCE INFORMATION

☐ Self-Pay (No Insurance) ☐ Insured

Primary Insurance

Insurance Company: _____ Phone: _____. Subscriber Name: _____

Subscriber DOB: _____ Subscriber ID / Member ID: _____ Group Number: _____

Subscriber Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Secondary Insurance

Insurance Company: _____ Phone: _____ Subscriber Name: _____

Subscriber DOB: _____ Subscriber ID / Member ID: _____ Group Number: _____

Subscriber Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

GUARANTOR INFORMATION (Complete if responsible party differs from patient)

Guarantor Legal Name: _____ Relationship to Patient: _____ Date of Birth: _____

Mailing Address: _____

City: _____ State: _____ ZIP Code: _____

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

Email Address: _____

Employment Status: _____ Employer Name: _____ Employer Phone: _____

Occupation: _____ Employer Address: _____

City: _____ State: _____ ZIP Code: _____

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____ Phone Number: _____

AUTHORIZATION AND FINANCIAL RESPONSIBILITY

I authorize Lenox Medical Clinic to release any medical information necessary to my insurance company, Medicare, Medicaid, or any other third-party payer for the purpose of processing claims and requesting payment of benefits, either to myself or directly to Lenox Medical Clinic.

I understand that I am financially responsible for all charges incurred, whether or not covered by my insurance plan. If my account is referred to a collection agency or attorney for non-payment, I agree to pay all associated collection costs, including reasonable attorney's fees.

I authorize my insurance benefits to be paid directly to Lenox Medical Clinic. I certify that the information provided on this form is accurate and complete, and I agree to notify the office of any changes.

_____ _____ _____

Signature of Patient or Authorized Representative *Printed Name* *Date*

_____ _____

Relationship to Patient (if not patient): *Reason patient unable to sign (if applicable):*