NEW PATIENT INFORMATION FORM

CHOPRA PEDIATRICS

1224 SEVENTH AVENUE ALTOONA, PA 16602

PHONE: 814-944-8784 FAX: 814-944-8625

Child's name: ______________________________ DOB: ____________ Sex: M _____ F ______

Address: ______________________________ Phone: ______________________________

City: ______________________________ State: _________ Zip: ______________________________

SSN: ______________________________ Pharmacy: ______________________________

Emergency Contact **(someone other than immediate caregivers):** ______________________________

Phone #: ______________________________ Relationship: ______________________________

Parents Name: ______________________________ SSN: ______________ DOB: ______________

Home Address: ______________________________ City: ______________________________

State: ______ Zip: ______________ Phone: ______________ Email: ______________________________

Employer: ______________________________ Phone: ______________________________

Occupation: ______________________________ Cell phone: ______________________________

Parents Name: ______________________________ SSN: ______________ DOB: ______________

Home Address: ______________________________ City: ______________________________

State: ________ Zip: ______________ Phone: ______________ Email: ______________________________

Employer: ______________________________ Phone: ______________________________

Occupation: ______________________________ Cell phone: ______________________________

Insurance Information (Please list subscriber if other than patient):

Primary: ______________________________ Policy #: ______________________________

Subscriber: ______________________________ Group #: ______________________________

Address: ______________________________

Secondary: ______________________________ Policy #: ______________________________

Subscriber: ______________________________ Group #: ______________________________

ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE PAYMENT of medical benefits per appropriate assignment(s) above to Rakesh K. Chopra, M.D. or any private practitioners rendering services, not to exceed the balance due of any aforementioned providers' regular changes for this period. I understand that I am financially responsible to the physician for charges not covered by this authorization.

RELEASE OF INFORMATION

I authorize the release of this medical record, any related studies and any other medical information to any doctor to whom I am referred, my legal counsel and to the applicable third-party payor.

Insured signature: ______________________________ Date: ______________________________