Eren & Atluri MD'S LLC

Internal Medicine

PERSONAL INFORMATION:

LAST NAME _____ FIRST NAME _____ MI ____

DATE OF BIRTH _____ AGE _____ SEX _____

ADDRESS _____ APT # _____

CITY _____ STATE _____ ZIP _____

RACE _____ ETHNICITY _____ LANGUAGE _____

SOCIAL SECURITY NUMBER _____ STATUS (S/M/D/W) _____

PHONE (HOME) _____ WORK _____ CELL _____

EMPLOYER _____

EMERGENCY CONTACT _____ PHONE _____

PRIMARY INCURANCE INFORMATION:

INSURANCE COMPANY _____

INSURED NAME _____

RELATIONSHIP _____ DOB _____

COPAY AMOUNT _____

POLICY NUMBER _____

GROUP NUMBER _____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY _____

INSURED NAME _____

RELATIONSHIP _____ DOB _____

COPAY AMOUNT _____

POLICY NUMBER _____

GROUP NUMBER _____

I authorize Drs. Eren & Atluri to apply for benefits on my behalf for services rendered by them. I request that payment from my insurance company may be made directly to Drs. Eren & Atluri. I certify that the information I have reported with regards to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing here in relieves me of the primary responsibility and obligation to pay for medical services provided, when statement is rendered.

I have received a copy of the Private Practices for Dr. Eren & Atlur, MD'S LLC.

_____

Signature Date