PATIENT INFORMATION

WELCOME TO OUR CLINIC.
PLEASE PRINT CLEARLY & COMPLETELY.

Paramount Medical Associates
5050 Crenshaw Rd Ste 100
Pasadena, TX 77505
Tel: 281-487-3111 Fax: 832-243-4362

PATIENT INFORMATION

Name: _____ DOB: _____ SSN: _____

Address: _____ APT / STE _____

City: _____ State: _____ Zip: _____

Telephone: _____ Work Phone: _____ Cell: _____

Check Appropriate Box: ☐ MALE ☐ FEMALE E-Mail:_____

☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

Patient's or Parent's Employer: _____

Business Address: _____

City: _____ State:_____ Zip:_____ Phone: _____

Spouse or Parent's Name: _____ Employer:_____ Work Phone: _____

If Patient is a Student, name of school / college: _____ City: _____ State: _____

Whom May We Thank for referring you ? _____

Person to contact in case of emergency: _____ Phone: _____

Preffered Pharmacy Name: _____ Phone:_____

INSURANCE INFORMATION

Name of Insured: _____ Relationship to Insured: _____

Birthdate: _____ Social Security Number: _____

Name of Employer: _____ Work Phone: _____

Address of Employer: _____ City: _____ State:_____ Zip _____

Insurance Company:_____ Group# _____

Ins. Co. Address:_____ City: _____ State:_____ Zip _____

How much is your Deductible ? _____ How much have you used ? _____ Max Annual Benefit ? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE ? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING

Name of Insured: _____ Relationship to Insured: _____

Birthdate: _____ Social Security Number: _____

Name of Employer: _____ Work Phone: _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Group#: _____

Ins. Co. Address: _____ City: _____ State: _____ Zip: _____

How much is your Deductible ? _____ How much have you used ? _____ Max Annual Benefit ? _____

AUTHORIZATION

Worker's Comp Only
I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim work Worker's Compensation benefits are denied.

Patient Signature: _____Patient Name:_____ Date: _____

ASSIGNMENT OF BENEFITS

I, the undersigned, hereby authorize payment of medical and surgical benefits directly to Paramount Medical Associates & Durga P. Sunkara, M.D. PA, Pasadena, Texas.

Signature: _____Patient Name: _____ Date: _____

RELEASE OF INFORMATION

I, the undersigned, hereby authorize the release of any medical information to process the insurance claim and request payment of the above insurance company (of companies) benefits either to myself or to the party who accepts assignment. I also authorize Durga Sunkara, M.D. to release medical records, written and oral, to the physician or mental health professional who referred me to him.

Signature: _____ Patient Name: _____ Date: _____

STATEMENT OF FINANCIAL RESPONSIBILITY

I, the undersigned, have read the above and realize that all medical and surgical charges incurred by me or my dependents for services rendered by Durga Sunkara, M.D. Pasadena, Texas are my financial responsibility. In the event my bill is not paid and there is no payment plan established, I authorize Durga Sunkara, M.D. to release my name and address for collection. All court fees, attorney's fees or other fees necessary to collect this amount are payable by me.

Signature: _____Patient Name: _____ Date: _____

Witness: _____ Date: _____

Consent for Treatment

I consent to evaluation and treatment and authorize Dr. Sunkara for medical care for myself, my child or dependant.

Signature:_____ Date:_____