

Mune Gowda M.D. & Associates

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Troy, MI 48084

DATE _____ REASON FOR VISIT _____

PATIENT'S NAME _____ MARITAL STATUS _____

DATE OF BIRTH ____/____/____ AGE _____ SS# _____ Email: _____

ADDRESS _____ APT# _____

CITY _____ STATE _____ ZIPCODE _____

PHONE _____

HOME _____ WORK _____ CELL _____

EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____

EMERGENCY CONTACT _____ PHONE # _____

INSURED'S NAME _____ DOB _____

SS# _____ RELATIONSHIP TO PATIENT _____

TYPE OF INSURANCE _____ PHONE # _____

REFERRING DOCTOR _____ PHONE # _____

FAMILY DOCTOR _____ PHONE # _____

IS THIS VISIT RELATED TO AN AUTO ACCIDENT? _____ OR WORK INJURY _____

NAME OF INSURANCE _____ DATE OF INJURY _____

CONTACT PERSON _____ PHONE # _____

INSURANCE ADDRESS _____ CLAIM # _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I authorize payment directly to Mune Gowda M.D. & Associates of any medical or surgical benefits. I understand the provider's charges may exceed the private insurance carrier payment, and if greater than such payment, I will be responsible for that amount. For cosmetic cases, I agree to pay the nonrefundable \$75 fee that will be applied towards my surgical procedure. In the future if I request a FMLA, time of leave and/or disability paperwork I understand and agree to pay a separate nonrefundable administrative fee of \$50. I understand that the \$50 is ONLY for the previously stated paperwork.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Mune Gowda M.D & Associates to release any information required in the course of my examination or treatment.

****I agree to be photographed by Mune Gowda M.D. & Associates for the purpose of medical necessity, medical publication and insurance authorization.** Yes _____ No _____

SIGNATURE _____ DATE _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____