Mune Gowda M.D. & Associates

26850 Providence Parkway Ste.125
Novi, MI 48374
3270 W. Big Beaver Rd. Suite 415
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 $150 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? _____