Anant Kumar, MD, MS

Patient Last Name________________________ First__________________________ Middle Initial_______

Address_____________________________ City______________ State_________ Zip Code_________

Home Ph#__________________ Cell Ph#___________________ Email _____________________________

Date of Birth__________________ Social Security #_________________________

Sex: M or F Marital Status: ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced ☐ Widowed

Education: ☐ High School Diploma ☐ GED-Grade Completed ______ ☐ Some College/Voc ☐ College Degree

Occupation ______________________ Employer_________________________ Work Ph#_______________

Emergency Contact__________________________ Phone #________________ Relationship___________

Primary Care Physician________________________ Phone #________________ Fax #________________

Is this a work or auto injury? Yes or No Claim #_________________ Date of Injury________________

Adjustor or Lawyer Name_________________ Phone #_______________

Primary Insurance

Insurance Name________________________ Policy #_____________________ Group #_______________

Insurance Address____

Insurance Phone #__________________________ Copay $_________ Effective Date________________

Name of Person Insured___________________________________ Relationship_____________________

Social Security Number______________________________ Date of Birth___________________________

Employer________________________ Address____

Secondary Insurance (if applicable)

Insurance Name________________________ Policy #_____________________ Group #_______________

Insurance Address____

Insurance Phone #__________________________ Copay $_________ Effective Date________________

Name of Person Insured___________________________________ Relationship_____________________

Social Security Number______________________________ Date of Birth___________________________

Employer________________________ Address____

I hereby authorize Anant Kumar, MD to treat the patient identified above. I acknowledge that I am responsible to pay all charges for all treatments administered by the physician to the patient. I understand that insurance may not pay for all charges and I understand that I am obligated to pay for all charges not paid by insurance. I also agree to pay reasonable attorney fees if my account is turned over to an attorney or collection agency. Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for non covered services. I also authorize the physician to release my information required in processing of this claim and all future claims.

Patient/Authorized Signature____ Date_________________