Allison Williams, M.D
Donald C George, M.D
Eveline Ane, M.D
Fredisia Francis, M.D
Michelle Starkey, CRNP
Girish Rao, MD
Paul Panavelil, MD
Laxmi Berwa, MD
Ali Rahimian, MD
John Vandam, MD

Personal Information

Name____Date of Birth __________
Last First Middle

Address ____
Street City State Zip

Home Phone__________________Work Phone_________________Cell________________

Fax__________________SS#________________Sex_______Marital Status____________

Spouse's Name______________________________Tel ____________________________

Emergency Contact______________________Tel_____________Relationship___________

Race: White/Black/Asian/Alaskan/Pac Isle/Other_________Ethnicity: Hispanic/Non-Hispanic________

Employer Information

Employer's Name______________________________Tel__________________________

Employer's Address____________________________Occupation_____________________

Insurance & Pharmacy Information

Primary Insurance Name_________________________________Tel__________________

Name of Insured___________________Relationship of Patient to Insured__________Copay_ DOB of Insured___________Member ID_______________Group ID___________

Secondary Insurance Name______________________________Tel__________________

Name of Insured___________________Relationship of Patient to Insured__________Copay_ DOB of Insured____________Member ID______________Group ID__________

Pharmacy Name_____________________Tel________________Fax________________

Address____Store No.________

Information and Assignment of Benefits

I authorize the release of medical information to my primary care physician, referring physician, or consults if needed and as necessary to process insurance claims, insurance authorizations and prescriptions. I also authorize payment of medical benefits to SMMG from my insurance company. I understand that payment is required for all services at the time they are rendered as well as co-payments and deductibles as due.

I certify that the information I have reported above is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Signature____Date________________

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