Rakesh Donthineni, M.D., MDA

Adult Spine Surgery
Orthopaedic Oncology

TODAY'S DATE

PATIENT REGISTRATION FORM

REFERRAL/ NEW PATIENT INFORMATION

LAST NAME	FIRST NAME	BIRTHDATE	AGE

STREET ADDRESS	☐ MALE ☐ FEMALE

CITY	STATE	ZIP CODE	SOCIAL SECURITY NUMBER

HOME PHONE	EMAIL ADDRESS

WHO REFERRED YOU TO OUR OFFICE?	ADDRESS	PHONE NUMBER

PRIMARY CARE PHYSICIAN	ADDRESS	PHONE NUMBER

GUARDIAN INFORMATION

FATHER'S NAME	CELL PHONE	WORK PHONE

MOTHER'S NAME	CELL PHONE	WORK PHONE

EMERGENCY CONTACT

NAME	RELATIONSHIP	HOME PHONE	WORK PHONE

INSURANCE INFORMATION- *PLEASE PRESENT INSURANCE CARD TO RECEPTIONIST*

PRIMARY INSURANCE COMPANY		**SECONDARY** INSURANCE COMPANY	
MAILING ADDRESS		**MAILING ADDRESS**	**CITY** **STATE**
SUBSCRIBER	**RELATIONSHIP/ D.O.B.**	**SUBSCRIBER**	**RELATIONSHIP/ D.O.B**
I.D. NUMBER	**GROUP NUMBER**	**I.D. NUMBER**	**GROUP NUMBER**
GUARANTOR- EMPLOYERS INFO		**GUARANTOR- EMPLOYERS INFO**	
SUBSCRIBER'S SIGNATURE		**SUBSCRIBER'S SIGNATURE**	

I, the above named patient hereby certify that all the above information is true and correct. I understand that if the above is not true or if I'm not eligible under the terms of my Medical Insurance Agreement, I am liable for all charges for services rendered. I authorize my Insurance Company to pay benefits directly to Dr. Rakesh Donthineni and authorize Rakesh Donthineni, M.D. to release any information required to process this claim. I understand that all payments (medical services, copays, deductibles and deposits) are due at time of service. Cash, checks and credit cards are acceptable methods of payment. **I also understand that I will be reponsible to pay a $25.00 charge due to all missed appointments which are not canceled 24 hours in advance.** This rule is strictly enforced.

PATIENT/ GUARDIAN SIGNATURE **DATE**