

Rakesh Donthineni, M.D., MBA

Adult Spine Surgery
Orthopaedic Oncology

TODAY'S DATE

PATIENT REGISTRATION FORM

REFERRAL/ NEW PATIENT INFORMATION

LAST NAME		FIRST NAME		BIRTHDATE	AGE
STREET ADDRESS				<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
CITY	STATE	ZIP CODE		SOCIAL SECURITY NUMBER	
HOME PHONE	CELL PHONE	EMAIL ADDRESS		DRIVERS LICENSE NO.	
WHO REFERRED YOU TO OUR OFFICE?		ADDRESS		PHONE NUMBER	
PRIMARY CARE PHYSICIAN		ADDRESS		PHONE NUMBER	
EMPLOYER'S NAME				WORK NUMBER	
EMPLOYER'S ADDRESS		CITY		STATE	ZIP CODE
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DOMESTIC PARTNER					
SPOUSE 'S NAME			CONTACT PHONE		

INSURANCE INFORMATION- PLEASE PRESENT INSURANCE CARD TO RECEPTIONIST

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

EMERGENCY CONTACT

NAME	RELATIONSHIP	HOME PHONE	CELL PHONE
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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 responsible to pay a \$25.00 charge due to all missed appointments which are not canceled 24 hours in advanced** This rule is strictly enforced.

PATIENT SIGNATURE

DATE