Rashmi Gupta, M.D.
Pediatric Institute for Epilepsy and Neurological Disorders
Phone: 248-354-0967 Fax: 248-354-6614

PATIENT REGISTRATION INFORMATION (Please Print Clearly)

Last Name: _____ First Name_____ MI: _____

Social Security #: _____ Date of Birth: _____ Sex: [ ] M [ ] F

Home Phone: _____ Cell Phone: _____

Street Address: _____ City: _____ State: _____ Zip Code _____

Sex: [ ] M [ ] F Marital Status: [ ] Single [ ] Married

Email Address: _____

Referring Physician OR Pediatrician: _____

Student Status: [ ] Full Time [ ] Part Time Name of School: _____

Emergency Contact: Name _____ Phone # _____

Address _____

RESPONSIBLE PARTY INFORMATION

Patient's relationship to responsible party: [ ] Self [ ] Spouse [ ] Dependent

If you are the responsible party, mark "self" and move down to "Insurance Information

Last Name: _____ First Name_____ MI: _____

Social Security #: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____

Street Address: _____ City: _____ State: _____ Zip Code _____

Employer and Employer's Phone #: _____

PRIMARY HEALTH INSURANCE INFORMATION

Primary Health Insurance Company: _____

Policy Holder: _____ Relationship to Patient: [ ] Self [ ] Spouse [ ] Dependent

Policy Holder Date of Birth: _____ Policy Holder Social Security # _____

Contract #: _____ Group # _____

SECONDARY HEALTH INSURANCE

Primary Health Insurance Company: _____

Policy Holder: _____ Relationship to Patient: [ ] Self [ ] Spouse [ ] Dependent

Policy Holder Date of Birth: _____ Policy Holder Social Security # _____

Contract #: _____ Group # _____

ASSIGNMENT, AUTHORIZATION & RELEASE

I hereby assign, transfer, and authorize payment of medical benefits to be paid to Rashmi Gupta, M.D. for services provided. I also authorize the release of information to billing agents, insurance carriers, or other responsible parties necessary to process claims and obtain reimbursement. I also authorize release of my visit to my PCP or referring doctor listed above. **I understand that I am financially responsible for all charges, whether or not they are covered by insurance. I understand that I am financially responsible for a $25.00 fee for missed office visits and/or a $100 fee for missed EEG appointments with less than 24 hours notice, payable before other services are rendered. Insurance will not pay no show/missed appointment fees. This would be your responsibility.**

Patient/Parent/Legal Guardian Signature: _____ **Date**: _____