

Seshagiri Rao, M.D., P.A.

BOARD CERTIFIED IN ALLERGY & IMMUNOLOGY

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NEW/UPDATED INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.)

NAME OF PRIMARY INSURANCE:

SUBSCRIBER'S NAME:	SUBSCRIBER SS #:	BIRTH DATE: / /	GROUP NO.:	POLICY NO.:	Co- PAYMENT: \$
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PATIENT'S RELATIONSHIP TO SUBSCRIBER:	<input type="checkbox"/> SELF	<input type="checkbox"/> SPOUSE	<input type="checkbox"/> CHILD	<input type="checkbox"/> OTHER _____
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NAME OF SECONDARY INSURANCE (IF APPLICABLE):	SUBSCRIBER'S NAME:	GROUP NO.:	POLICY NO.:
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PATIENT'S RELATIONSHIP TO SUBSCRIBER:	<input type="checkbox"/> SELF	<input type="checkbox"/> SPOUSE	<input type="checkbox"/> CHILD	<input type="checkbox"/> OTHER _____
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I, _____, agree that the information pertaining to the health insurance coverage of myself or a dependant which I have provided to the office of Dr. Seshagiri Rao, MD is correct and complete to the best of my knowledge. I fully understand that to the extent that any of the aforementioned health insurance information I have provided is incorrect or incomplete, *I am fully responsible for any resulting charges.*

Patient/Subscriber Signature

Date:

Office Staff Signature

Date: