BEL AIR/HDG PEDIATRIC CENTERS

RASTOGI, YIM, WINKLE, M.D.

DRUYOR, FNP-C

PATIENT INFORMATION SHEET

(Patients 18 years of age and older)

Patient Name_____ DOB:_____

Home Address (Street, City, State)_____Zip _____

Employer_____Address_____

Social Security #_____ M/F ___ Race _____

Phone numbers:

Home#_____

Cell # _____

Email for patient portal _____

INSURANCE INFORMATION

Primary Insurance _____ policyholder _____

Secondary Insurance _____policyholder_____

If policy holder is other than yourself, please complete below:

Policyholder of Insurance _____ DOB: _____

Address of Policyholder (Street, City, State)_____

Employer _____Address_____

Phone # _____

SS#_____

I authorize the release of any medical information necessary to process claims for payment of medical charges. I, also, authorize payment of medical benefits to Bel Air/Havre de Grace Pediatrics for services rendered. I understand that all services rendered on a payment for services basis. If collections becomes necessary, the undersigned shall pay shall pay all costs including attorney's fees.

Patient _____ Date_____