Desai Medical Center

3290 N. Ridge Road, Suite 100, Ellicott City, MD 21043
Phone: (410)313-9292 Fax: (410)313-9293 www.desaimedicalcenter.com

Date _____ Time _____ ☐ Kartik J. Desai, MD ☐ Smita A. Patel, MD

PATIENT INFORMATION

Last Name _____ First Name _____ MI _____

Date of Birth _____ Age _____ Sex M F Marital Status _____ Race _____

Address _____ Apt _____ City _____ State _____ Zip _____

Social Security # _____ Driver's License # _____ State _____

Home Phone _____ Work Phone _____ Mobile _____

Email _____ Occupation _____

Pharmacy Name _____ Pharmacy Phone _____

Employer / School _____ Phone _____

Employer Address _____ City _____ State _____ Zip _____

Primary Insurance Information (Please circle one)

Responsible Party Primary Insurance

SELF PAY PPO HMO MEDICARE MEDICAID MEDICAL ASSISTANCE DISCOUNT PLAN EPO POS

Primary Insurance	Effective Date	ID	Group No.
Policy Holder Name / Responsible Party	Relationship to Patient	Policy Holder Date of Birth	Policy Holder Social Security Number
Policy Holder / Responsible Party Address		City	State / Zip
Policy Holder Employer Name and Address		City	State / Zip

Secondary Insurance Information (Please circle one)

Secondary Insurance

PPO HMO MEDICARE MEDICAID MEDICAL ASSISTANCE DISCOUNT PLAN EPO POS

Secondary Insurance	Effective Date	ID/ Group Number	
Policy Holder Name / Responsible Party	Relationship to Patient	Policy Holder Date of Birth	Policy Holder Social Security Number
Policy Holder / Responsible Party Address		City	State / Zip
Policy Holder Employer and Address		City	State / Zip

Type of Payment (Please circle one)

Co Payment Amount $ CASH CREDIT CARD CHECK CHECK NO.

Emergency Contact Name _____ **Relationship** _____ **Phone** _____

Payment and Authorization Consent

I understand that If I do not have a valid authorization from my Insurance company to cover services performed, I will be personally responsible for the charges in full, and I agree to pay, in full, any co-pays , deductibles, or coinsurance amounts that my insurance company deems my responsibility. I here by authorize Desai Medical Center to release information to my Insurance company, workers' compensation carrier or Medicare, Medicaid, Medical Assistance. I authorize this practice to release my medical information, including privileged, sensitive information, to any hospital, physician or provider.

I authorize the copy of this authorization to be used in place of the original.

Signature Patient / Guardian _____ **Date** _____