# Welcome!

BatraVision

15051 Hesperian Blvd. Suite A
San Leandro, CA 94578
**TEL:** (510) 276-1212 **FAX:** (510) 276-1313

## PATIENT INFORMATION

Date ____________ Soc. Sec. # ____________ Birthdate ____________

Name ______________________________
Last Name First Name **Initial**

Address ______________________________ Home Phone ____________

City ____________ State ____________ Zip ____________

Sex: ☐ **M** ☐ **F** ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer ______________________________ Business Phone ____________

Business Address ______________________________ Occupation ____________

Who should we thank for referring you? ______________________________

In case of emergency, who should we contact? ______________________________ Phone ____________

## PRIMARY INSURANCE

Person Responsible for Account ______________________________
Last Name First Name **Initial**

Relationship to Patient ____________ Birthdate ____________ Soc. Sec. # ____________

Address ______________________________ Home Phone ____________

City ____________ State ____________ Zip ____________

Responsible Party Employed By ______________________________ Business Phone ____________

Business Address ______________________________ Occupation ____________

Insurance Company ______________________________

Subscriber I.D. # ______________________________ Group # ____________

## ADDITIONAL INSURANCE (if applicable)

Insured Name ______________________________
Last Name First Name **Initial**

Relationship to Patient ____________ Birthdate ____________ Soc. Sec. # ____________

Address ______________________________ Home Phone ____________

City ____________ State ____________ Zip ____________

Insured Employed By ______________________________ Business Phone ____________

Business Address ______________________________ Occupation ____________

Insurance Company ______________________________

Subscriber I.D. # ______________________________ Group # ____________

## ASSIGNMENT and RELEASE

I authorize any insurance company, organization, employer, hospital, physician, dentist, or pharmacist to release any information requested with regards to processing my claims. I request that payment of authorized Medicare, MediCal or insurance benefits be made directly on my behalf to *V.Nicholas Batra, M.D., Inc.*. I further request that any supplemental insurance benefits be paid also as stated above. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I certify that the information I furnish is true and correct. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important. AS THE RESPONSIBLE PARTY, I AGREE THAT ALL CHARGES THAT ARE NOT DIRECTLY PAID BY MY INSURANCE COMPANY WILL BE MY RESPONSIBILITY.

***PATIENT/RESPONSIBLE PARTY SIGNATURE*** ______________________________ ***DATE*** ____________