

**ROBERT MAHANTI, M.D.**

**PATIENT INFORMATION**

Patient's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
 Single  Married  Male  Female  
Birth Date: \_\_\_\_\_  
  
Occupation: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Ext. \_\_\_\_\_

**SPOUSE OR LEGAL GUARDIAN**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
 Single  Married  Male  Female  
Birth Date: \_\_\_\_\_

**EMERGENCY CONTACT OR CARETAKER**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_  
Who may we thank for referring you to our office? \_\_\_\_\_  Yellow Pages  Internet  
Would you like to learn more about LASIK Surgery?  Yes  No  Maybe

**INSURANCE INFORMATION**

**Primary Insurance**

Insurance Company: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
ID Number/Social Security #: \_\_\_\_\_  
Group Number: \_\_\_\_\_  
Insured's Date of Birth: \_\_\_\_\_

**Secondary Insurance**

Insurance Company: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
ID Number/Social Security #: \_\_\_\_\_  
Group Number: \_\_\_\_\_  
Insured's Date of Birth: \_\_\_\_\_

**AUTHORIZATION FOR TREATMENT, RELEASE OF INFORMATION, FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS**

I authorize treatment of the above to pay all fees and charges for such treatment, promptly upon presentation of statement, unless prior credit arrangements have been agreed upon in writing. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing date. Although this office may assist me in filing and insurance claims, I understand that I am fully responsible for the balance and agree that payment will not be delayed because of any pending insurance claim. I authorize all insurance benefits, unless previously paid by myself, to be paid directly to this physician and also authorize the physician to release any information required in the processing of the insurance claim. Once payment is received from the insurance company, I will receive only one statement for the balance. It is expected that payment will be made within 10 days of receipt of first statement. If payment is not received, it will be considered past due and may be sent to collections.

**PATIENTS WITH MEDICARE OR MEDICARE REPLACEMENT**

I request that payment under the medical insurance program be made on my behalf to Robert L. Mahanti, M.D., for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Healthcare Financing Administration and its agents any information needed to determine these benefits for the benefits payable for related services. I further permit a copy of this authorization to be used in place of the original. Refractions are a non covered service of Medicare and is the patient's responsibility.

I certify that I have given proper insurance information. If a referral is necessary with my insurance plan, it is my responsibility to obtain the necessary referral.

**ALL PATIENTS MUST SIGN HERE:**

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*Patient Information*