COLUMBUS CENTER FOR REPRODUCTIVE
ENDOCRINOLOGY & INFERTILITY, L.L.C.

2323 Whittlesey Road
Columbus, GA 31909

Prakash J. Thiruppathi, M.D.

CONFIDENTIAL DEMOGRAPHIC INFORMATION
PLEASE ANSWER ALL QUESTIONS HONESTLY & COMPLETELY

Patient's Name (as it appears on your insurance card):

____

(FIRST) (MI) (LAST)

Social Security Number: ____________________________ Date of Birth: ___________________________

Address: ____ City: _________________________________

State: _________ Zip: _________ Home Telephone Number: __________________________________

Work Telephone Number: ____________________ Cell/pager Number: ____________________________

Are we able to contact you at these numbers: YES____________ NO __________

Marital Status: Single ________ Married: __________ Divorced: __________ Seperated: ___________

Driver's License Number: _________________________ State: ___________________________________

Spouse's Information (or if minor, Parent's Name)

Name of Spouse: ____________________________________ Date of Birth: __________________________

Spouse's Employer: ___________________________ Social Security Number:___________________________

Address if different than above:

____

INSURANCE INFORMATION

Primary
Insurance Carrier:

____

Policy Holder: _______________________________ Policy Number: ______________________________

Secondary
Insurance Carrier:

____

Policy Holder: _______________________________________ Policy Number: _________________________

EMPLOYMENT INFORMATION

Patient's Employer: _______________________________ Work Number: ________________________

Address:____

Occupation:
____

REFERRING DOCTOR

Referring Doctor's Name: __________________________ Phone Number: _________________________

Address:____

Reason you were referred:
____

Would you like us to give out any information about your medical treatment being performed in this office to anyone beside yourself (i.e. spouse, parent, sibling, friend)? Please understand that by checking "**YES**", you are giving this office the right to disclose personal information regarding your treatment to the person(s) listed below. YES____________ NO _____________

If so, Name: ____________________________________ Date of Birth: _____________________________

Did you receive a copy of the "Notice of Privacy Policies for the Columbus Center for Reproductive Endocrinology & Infertility, L.L.C." brochure? YES __________ No __________

Please read this brochure in its entirety.

I hereby certify that the above information is complete and correctly stated to the best of my ability.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to my attending physician or authorized billing company of the medical insurance benefits otherwise payable to me for services rendered. I understand that I am responsible for all charges not covered by this assignment (all non-covered services). I also understand that my insurance benefits were verified over the phone and is **NOT** a guarantee of payment from my insurance company. My signature also authorizes the release of information required by third party payor to process my insurance claims.

My signature below is my authorization to use or disclose my information.

Signature: ____ Date: ___________________________

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I, (patient's name),___________________________________, understand that Dr. Thiruppathi may order laboratory, x-ray, and/or ultrasound test which may or may not be performed in this office.

The laboratory tests may include, but not limited to: Hormone levels, RPR, Hepatitis B SaG, RH type and screen.

The x-ray and ultrasound test may include but are not limited to: vaginal ultrasound, DEXA Scan, mammogram, CT Scan, and MRI.

I, as the patient, take full responsibility for payment of these procedures, whether performed in the office or off site, after correspondence with insurance has been completed. I also understand that if for any reason I do not wish any of these procedures to be performed I must inform Dr. Prakash Thiruppathi.

____ _________________________________

Patient's Name Date