

Karle Medical Group, P.C.

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Amir Sankari, M.D.

Patient Demographic Information

Your Karle Medical Group Doctor: _____

Date: _____

Patient Information

Last Name _____ First Name _____ MI _____ Soc. Security # _____

Street Address _____ Suite/Apt # _____

City _____ State _____ Zip-Code _____

Date of Birth _____ Sex _____ Marital Status _____

Cellular Phone _____ Work Phone _____ Home Phone _____

May we leave messages? On (Y/N) Cell Phone _____ Work Phone _____ Home Phone _____

Email _____

Emergency Contact _____ Emergency Contact's Phone # _____

*Preferred Language _____ *Race/Ethnicity _____ (If you decline to declare, write "Decline".)

Preferred Pharmacy Name and Cross Streets: _____ Pharmacy Phone _____

Responsible Party (Subscriber/Insurance Contract Holder) – the **4 bolded** items are required if you are not the insurance subscriber

Relationship between the patient listed above and the primary insurance holder? _____

RP Last Name _____ **RP First Name** _____ MI _____ Soc. Security # _____

Street Address _____ Suite/Apt # _____

City _____ State _____ Zip-Code _____

RP Date of Birth _____ Sex _____ Marital Status _____

Home Phone _____ Work Phone _____ Cell Phone _____

Insurance Information

Insurance Company _____ Subscriber Name _____

Insurance Contract Number _____ Group Number _____ Effective Date _____

Financial Responsibility Statement

This information is accurate and true to the best of my knowledge. I acknowledge and accept responsibility for payment of services rendered, including reasonable attorney's fees and costs of collection in the event of default. I understand that co-payment, deductibles, and patient balances are due at the time of service. If I do not pay at the time of service I will be charged a \$5.00 account maintenance fee. I further understand that if a payment becomes 120 days past due, delinquency at the lesser of the annual rate of 26%, or the maximum allowable rate will be due on delinquent amounts from the date the payment was due. Any debt that is over 365 days overdue will be charged a 50% collection agency fee which will be required to be paid by the owing patient.

Signature: _____ Date: _____