**SUNDAR INTERNAL MEDICINE ASSOCIATES, PA**
**511 RUIN CREEK ROAD, SUITE 203**
**HENDERSON, NC 27536**
**(252) 492 6127**

# PATIENT INFORMATION REGISTRATION FORM

## Personal Information

Last Name: ____________________ First: ____________________ Middle: ______________

SSN: ______________________________ Date of Birth: __________________________

Address: ______________________________________________________________________

Phone Number: ____________________ Work Number: __________________________

Cell Number: ______________________ Email Address: __________________________

Spouse Name & Cell Number: ______________________________________________

## Insurance Information

Primary Insurance: ________________ Policy No: ______________________

Secondary Insurance: _________________ Policy No: ______________________

## Emergency Contact Information

Name: ______________________________ Relationship: ____________________
Phone No: ________________ Cell No: ________________ Work: _______________
Name: ______________________________ Relationship: ____________________
Phone No: Cell No: Work:

**We ask all patients to show their insurance card so that we can make copies of them. We cannot render service on the assumption that our charges will be paid by the insurance company. All services are charged directly to the patient, and he or she remains personally responsible for the payment. As a courtesy, however, we will prepare any necessary reports and itemization to assist in making collections from insurance companies and will credit any such collections to the patient's account.**

**ASSIGNMENT OF BENEFITS**

**I, ______________________, hereby assign, transfer and set over to Sundar Internal Medicine Associates, PA and associated MD's all of my rights, title and interest to my medical reimbursement benefits under my insurance policy with the above mentioned insurance company. Although covered by insurance, I am aware that I am personally responsible for all charges. A Photostat copy of this authorization will be as valid as the original.**

**Signature of Patient/Guardian: _________________________________________Date: __________________**