Registration Form
Office of Dr. Sujata Qasba

Today's Date: _____

Patient's Name:_____ Date of Birth:_____
Home Address: _____
Home Phone #:_____ Cell#:_____
Patient lives with o Both Parents o Mom o Dad o Other:_____
Primary Family Email:_____

Mother's Name _____Social Security #_____DOB: _____
Home Phone # _____Work Phone #_____Cell Phone #_____
Employer_____Occupation_____

Mother's Name _____Social Security #_____DOB: _____
Home Phone # _____Work Phone #_____Cell Phone #_____
Employer_____Occupation_____

Emergency Contact (In case we are unable to reach the parents:
Name:_____ Phone #:_____Relationship:_____

Insurance/Billing Information:

*Please bring us your insurance card, we will make a copy of it
*Please inform us if you have any secondary insurance. Claims will be denied if we do not have the correct information.

I hereby authorize direct payment of medical benefits to Dr. Sujata Qasba for services rendered by her or her associate. I understand that I am responsible for any balance not covered by my insurance.

I hereby authorize Dr. Qasba to release any medical information or incidental information that may be necessary for medical care or in processing application for financial benefits.

[_____] By initialing here, I give Dr. Qasba's offce permission to email me appointment reminders and non-urgent communications.
[_____] By initialing here, I understand there is a $25 missed appointment fee, of not cancelled within 24 hrs. No exceptions will be made.

Name of Person Completing this Form:_____Relationship:_____

Signature:_____ Date:_____