



Dr. Bawa & Associates, P.A.
Board Certified, Internal Medicine
45 Sugar Sand Lane, Santa Rosa Beach, FL-32459
Phone: 850-534-4170 Fax: 850-534-4174

PATIENT REGISTRATION FORM

Patient Information

Name: (Last) _____ (First) _____ (M.I.) _____
Address: _____
City: _____ State: _____ Zip: _____
Home Ph: (_____) _____ Work Ph: (_____) _____ Cellular Ph: (_____) _____
Date of Birth: ____/____/____ Age: _____ Gender: M F Social Security #: _____ - _____ - _____
Email Address: _____ Marital Status: _____
Employer: _____ Occupation: _____
Purpose of Today's Visit _____
Referred by _____

Primary Insurance Information

Policy Holder's Name (Last) _____ (First) _____ (M.I.) _____
Patient's Relationship to Insured: Self Spouse Child Other _____
Date of Birth: ____/____/____ Age: _____ Gender: M F Social Security #: _____ - _____ - _____
Insurance Company _____
Group # _____ Policy/Contract/ID # _____
Insurance Address _____ City _____ State _____ Zip _____
Co-pay \$ _____

Secondary Insurance Information

Policy Holder's Name (Last) _____ (First) _____ (M.I.) _____
Patient's Relationship to Insured: Self Spouse Child Other _____
Date of Birth: ____/____/____ Age: _____ Gender: M F Social Security #: _____ - _____ - _____
Insurance Company _____
Group # _____ Policy/Contract/ID # _____
Insurance Address _____ City _____ State _____ Zip _____
Co-pay \$ _____

AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT

I authorize treatment of the person named above and accept financial responsibility for all treatment provided. I authorize Nitin Bawa MD, P.A., to provide to my insurance company all information necessary to process this claim. I hereby authorize and direct my insurance carrier to pay directly to Nitin Bawa MD, P.A., any benefits due me under my insurance plan. I understand that it is my responsibility to obtain proper referral authorization. I agree that interest shall accrue at a rate of 1.5% monthly on any unpaid balance beginning 60 days from the date original invoice.

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the notice of privacy practices supplied by Nitin Bawa Professional Associates.

(NOTE: Privacy practices are in the plastic sheets attached to the clipboard.)

Patient or Guarantor Signature: _____ Date: ____/____/____
(If patient is minor, signing also gives authorization to treat).

Relationship to Patient: _____