GOPAL REDDY, MD, FACS, PC
500 WALTER NE, SUITE 204
Phone (505)-842-5518 Fax (505)247-8509
Patient Information

PLEASE PRINT CLEARLY

Patient
Name_____Date_____

Social Security #_____-_____-_____Date of Birth_____

Race: Hispanic_____Anglo_____Native Ameri_____African Amer_____Asian_____Other_____

Marital Status S_____M_____W_____D_____ Sex: Male_____Female_____

Mailing Address or PO Box_____

City_____State_____ZipCode_____

Home Phone Cell Work
(505) (575)_____ (505) (575)_____ (505) (575)_____

Medical Record Access ____Yes____No Email Address_____

Employed By_____

Emergency Contact_____Phone_____

Relationship_____

Referred By Dr._____Primary Care Dr._____

Insurance Company_____Primary Insured_____

Pharmacy_____Location_____Phone_____

ASSIGNMENT OF BENEFITS:
I hereby assign all medical, surgical, major medical insurance benefits for services rendered by /to Dr Gopal Reddy. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment from my insurance company.
In the event this account is assigned to collection for non-payment, I agree to pay all costs of collection, including reasonable attorney fees.
I hereby authorize Dr. Reddy to obtain medical records from other physicians and /or hospitals.
I hereby authorize Dr. Reddy to fax medical reports to my primary and/or referring physician.

Signed_____Date_____