INTAKE FORM: Dr. Sanjay Ghosh -- Pacific Neurosurgery & Spine Medical Group, Inc.; San Diego Neurotrauma Associates, Inc.; Premiere Surgical Assistants, Inc.

PLEASE COMPLETE THE FOLLOWING, it is required for your electronic file.

Last Name: ____________________ First Name: ____________________ MI: _____

DOB: ____________ SS #: ________________ Sex: ☐M ☐F

Address: ____

City/State: ________________ Zip: __________ Marital Status: ☐M ☐S ☐D ☐W

Home Phone: ____________ Cell Phone: ____________ E-mail: ____________

*we do not guarantee confidentiality of information if you choose to engage in email exchange.

Work Phone: ____________ Occupation/Employer: ____________________

Prefer to be reached at: ☐Home ☐Cell ☐Work Ok to leave detailed messages? ☐Yes ☐No

Race: ____________ Ethnicity: ____________ Language: ____________

Primary Care MD: ____________________ Phone: ____________

Referring MD: ____________________ Phone: ____________

<u>Guarantor/Person Responsible for Payment:</u> ☐ Check here if <u>patient</u> is responsible

Name: ____________________ Relationship to Patient: ____________

Address (if different): ____

DOB: ____________ SS #: ________________

<u>Emergency Contact</u>: ________________ Relationship: __________ Ph: ____________

*Is there anyone you wish us to share your medical information with? If not, write "none".

____

<u>Insurance Information:</u>

Primary Insurance: ____________________ Effective Date: ____________

Member ID: ________________ Group # (if applicable): ________________

Secondary Insurance: ____________________ Effective Date: ____________

Member ID: ________________ Group # (if applicable): ________________

I hereby assign to the medical service corporations referenced above any and all contractual, legal and equitable rights that I may have to payment from my medical insurance carrier(s) for any and all medical services rendered to me by Dr. Sanjay Ghosh or by other medical professionals on behalf of those medical service corporations. I hereby direct that all payments by my insurance carrier(s) shall be made directly to those corporations. I authorize each of these corporations to release to my insurance carrier(s) any and all information necessary to process my claim for benefits and to take any necessary legal action as an assignee to collect those benefits from my insurance carrier(s). I understand that I am responsible for payment of all sums billed for medical services provided to me over and above the sums that are actually and promptly paid by my insurance carrier(s), and I shall promptly pay those sums if requested to do so.

Patient Signature: ________________________ **Date:** ____________