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NEW/UPDATED INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Name of Primary Insurance:					
Subscriber's name:	Subscriber SS #:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other _____	
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other _____	

I, _____, agree that the information pertaining to the health insurance coverage of myself or a dependant which I have provided to the office of Dr. Seshagiri Rao, MD is correct and complete to the best of my knowledge. I fully understand that to the extent that any of the aforementioned health insurance information I have provided is incorrect or incomplete, *I am fully responsible for any resulting charges.*

Patient/Subscriber Signature Date:

_____

Office Staff Signature Date:

_____