

Raman Verma, M.D.
Internal Medicine -Acupuncture
5128 W. Cypress Avenue
Visalia, Ca. 93277 Tel. (559) 713-1111

Patient Information

Last Name: _____ **First Name:** _____ **MI:** _____
Home Address: _____
Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____
Date of Birth: _____ **Sex:** _____ **Marital Status:** _____
Social Security Number: _____ **Email Address:** _____
Employer: _____

Primary Language: English Spanish Other

Race: *Please select one*

- | | | |
|---|---|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> White | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Hispanic | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> Other Race: _____ | <input type="checkbox"/> Refuse to Report | |

Ethnicity: *Please select one*

- Hispanic Non-Hispanic Refuse to Report

Insurance Information

Insurance Name: _____
Subscriber Number: _____
Group Number: _____
Insurance Address: _____
Subscriber: _____
Subscriber's Name: _____
Subscriber's Social Security Number: _____

Secondary Information

Insurance Name: _____
Subscriber Number: _____
Group Number: _____
Insurance Address: _____
Subscriber: _____
Subscriber's Name: _____
Subscriber's Social Security Number: _____

Medical Information

Pharmacy: _____ **Phone:** _____
Emergency Contact: _____ **Phone:** _____ **Relation:** _____
Who is financially responsible for this bill? _____

Authorization

I authorize the release of medical information necessary to process medical benefits and I authorize payment of medical benefits to Raman Verma, M.D. for services by his office.

Signed _____ Date: _____