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: _____

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

Name: _____ Relationship to Patient: _____

Address (if different): _____

DOB: _____ SS #: _____

Emergency Contact: _____ Relationship: _____ Ph: _____

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

_____

Insurance Information:

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:** _____