Naresh G. Rana, M.D., P.A.
733 Bloomfield Ave
Bloomfield, NJ 07003
Phone: 973-743-7707 | Fax: 973-743-7808

PATIENT INFORMATION
(PLEASE PRINT)

☐ Mr. ☐ Ms. ☐ Dr. ☐ Mrs. ☐ Miss	Patient's Last Name:	First:	Middle Initial:
Marital status: ☐ Single ☐Mar ☐ Div ☐ Sep ☐ Wid	Nickname:	Birth/Maiden Name:	
Birth Date:	Gender: ☐ M ☐ F	SSN:	Email Address:
Driver's License Number:	State:	Expiration Date:	
Home phone:	Work phone:	Cell phone:	
Address:	City:	State:	ZIP Code:
Occupation:	Employer & Address:	Employer phone:	
Referred to practice by:	☐ Dr. _____	☐ Patient _____	☐ Other _____

May we include your name on the thank you letter we send to the person who referred you to our practice? ☐ Yes ☐ No

INSURANCE INFORMATION
(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person responsible for bill: (if self, please skip to Primary Insurance)		Is this person a patient at our practice? ☐ Yes ☐ No
Date of Birth:	Address:	Home Phone:
Occupation:	Employer & Address:	Employer phone:

****Policy Holder's Name, SSN, Date of Birth and Relationship to Patient are REQUIRED to file all insurance claims.****

Primary Health Insurance Company:

*Policy Holder's Name:(as it appears on insurance card)		*SSN:			*Birth date:
Group Number:		Policy Number:			Co-Payment: $
*Patient's relationship to Policy Holder:	☐ Self	☐ Spouse	☐ Child	☐ Other	

IN CASE OF EMERGENCY (LOCAL FRIEND/ RELATIVE)

Name:	Relationship:	Phone #:	Alt. Phone #:
Name: (not living at same address)	Relationship:	Phone #:	Alt. Phone #:

The above information is true to the best of my knowledge. I authorize Naresh Rana MD PA or insurance company to release any information required to process my claims.
I auhorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I understand payment is due at time of service, and that Naresh Rana MD PA reserves the right to dismiss patients that fail to keep their accounts current after reasonable attempts to collect payments have been made. I further agree to pay all reasonable costs and late fees should my account be turned over to collections.

Patient/Guardian Signature: _____ Date: _____