AMANDEEP PAL M.D. PLLC
6000 BROCKTON DR STE 101
LOCKPORT N.Y. 14094
716-795-0077

NAME_____DATE OF BIRTH_____ SS#_____
ADDRESS_____CITY_____ STATE_____
ZIP_____
HOME PHONE_____ WORK_____ CELL_____

MARITAL STATUS M__D__W__S__C__ GENDER M__ F__
SPOUSE OR PARENT NAME _____

EMPLOYER_____ADDRESS_____
PHONE#_____

INSURANCE POLICY HOLDER NAME _____
PRIMARY INSURANCE CO_____ ID#_____
SECONDARY INSURANCE _____ ID#_____
THIRD INSURANCE CO _____ ID#_____

WORKERS COMP OR NO FAULT CARRIER _____

EMERGENCY CONTACT NOT LIVING WITH YOU
NAME_____PHONE#_____
RELATIONSHIP_____
ALLERGIES _____
PHARMACY USED_____ PHONE #_____

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER PATIENT IS RESPONSIBLE FOR COPAY, YEARLY DEDUCTABLE AND NON COVERED SERVICES. ALL CHARGES ARE DUE AT THE TIME OF SERVICE. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO AMANDEEP PAL M.D. PLLC FOR SERVICES RENDERED TO ME.

SIGATURE_____ DATE_____
PRINT NAME _____