B. S. Khehar, M.D., INC.

BHUPINDER S. KHEHAR, M.D.

4060 Fourth Avenue, Suite 335, San Diego, CA 92103
(619) 291-9285 • Fax (619) 291-9289

Date: ____________________

Patient Information:

______________________________ Home Ph. # ____________ Cell # ____________

Last Name First Name Initial

Sex: M F

______________________________ Student Status: Full Time ☐ Part Time ☐

Street Address Apt. # City State Zip

DOB: ____/____/____ M S W D ____________ Employer Phone # ____________

Month Day Year Circle Marital Status Social Security No.

Employed By: ____________ Address: ____________

Occupation: ____________ City, State, Zip: ____________

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT (if other than patient). If Minor/Student fill out information for both parents below:

Husband/Father (circle one) ____________

Name DOB Soc. Sec. # Phone No. Ext. No.

Employed By: ____________ Address: ____________

Occupation: ____________ City, State, Zip: ____________

Wife/Mother(circle one) ____________

Name DOB Soc. Sec. # Phone No. Ext. No.

Employed By: ____________ Address: ____________

Occupation: ____________ City, State, Zip: ____________

	PRIMARY INSURANCE	SECONDARY INSURANCE
INSURANCE INFORMATION:	Name of Insurance	Name of Insurance
	SS#/ID#	SS#/ID#
	Group No.	Group No.

Primary Physician: ____________ (____) ____________

Name Phone No.

Address: ____________ City, State, Zip: ____________

Patient Referred By: Name: ____________ (____) ____________

Phone No.

Address: ____________ City, State, Zip: ____________

If Hospital Referred: ____________ Date of Hospitalization/Emergency: ____________

Name of Hospital Month/Day/Year

In Case of Emergency Contact:

	1	2
Name		
Address		
City, State, Zip		
Phone		

Drivers License: ☐ Self Lic.# ____________ Expires: ________ ☐ Spouse Lic. # ____________ Expires: ________

AGREEMENT

In order to prevent any misunderstanding about medical insurance, we wish to point out that.
No. 1 – All medical services furnished are charged directly to the patients.
No. 2 – Patients are personally responsible for payment of bills unless a contractual agreement exists to the contrary.
No. 3 – Patients should expect to keep their accounts current while waiting for their insurance company to make payments.
Your insurance coverage is a contract between you and your insurance company to help you meet medical expenses. It is not possible for us to provide service on the basis that the insurer will always pay all charges, as coverage varies so greatly. We are happy to bill your insurance carrier with an assignment of benefits at no charge to help collect your benefits. When your insurance sends us a check, we will credit the amount to your account or refund it to you if your bill is already paid. You will continue to receive statements of your account if you have an outstanding balance, even though your insurance has been billed.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE BHUPINDER S. KHEHAR, M.D. TO FURNISH INFORMATION TO INSURANCE CARRIER REGARDING MY ILLNESS AND TREATMENTS, AND ASSIGN TO THEM ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO ME OR MY DEPENDENTS. I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ANY ALLOWED AMOUNT THAT IS NOT COVERED BY MY INSURANCE.

____________ ____________

Date Patient or Responsible Party Signature