**Manoj Khatore, M.D.,F.A.C.C.**
1901 Outlet Center Drive #260 • Oxnard, CA 93036 • (805) 604-1824

# Patient Information Form

**Patient Information**
*(Please print)*

Name ______________________
Address ______________________
City ______________________ Zip ________
Home Phone ____________ Cell # ____________
Birth Date ____________ Sex (Circle One) M F
Marital Status (Circle One) S M D W
Social Security No. ______/______/______
Employer ______________________
Employer's Address ______________________
______________________
Work Phone ______________________
Driver's License No. ______________________
Referred by ______________________
email ______________________

**Medical Insurance Information** *(Primary)*

Subscriber Name ______________________
Relationship to Patient ______________________
Insurance Co. ______________________
Policy No. ______________________
Group No. ______________________
Co-pay Amount ______________________

**Responsible Party Information**
*(If other than patient)*

Name ______________________
Address ______________________
City ______________________ Zip ________
Birth Date ____________ Sex (Circle One) M F
Relationship to Patient ______________________
Social Security No. ______/______/______
Employer ______________________
Employer's Address ______________________
______________________

**Emergency Contact**

Name ______________________
Phone ______________________

**Medical Insurance Information** *(Secondary)*

Subscriber Name ______________________
Relationship to Patient ______________________
Insurance Co. ______________________
Policy No. ______________________
Group No. ______________________
Co-pay Amount ______________________

**Authorization to Pay Benefits to Physician**

I hereby authorize payment directly to Manoj Khatore, M.D. of surgical and/or medical benefits, if any, payable for services rendered or supplies provided. I understand that I am responsible for paying any amounts not covered by insurance.

**Authorization to Release Medical Information**

I hereby authorize release of any medical or other information necessary to process any claims.

**Payment Terms**

Cash payment or proof of insurance is required at time of service. Co-pay must be paid before seeing the doctor.

Signature ______________________ Date ____________