PERMIAN INTERNAL MEDICINE ASSOCIATES (PIMA)

403 PITTSBURG AVENUE, ODESSA, TEXAS 79761
Phone (432) 332-3400 Fax (432) 332-6500 www.pima1.com Patient Portal: http://9460.portal.athenahealth.com

UPDATED ESTABLISHED PATIENT REGISTRATION FORM 2019

Date_____
Referred by _____ Primary Care Dr. _____

PATIENT INFORMATION
Last Name _____ First Name _____ MI _____

DOB _____ Sex: Male Female Status: Single Married Widowed Divorced

SS#_____ Driver's License # _____

Address:_____ City/State/Zip _____

Home # (_____)_____ Cell # (_____)_____ Work\Other (_____)_____

E-Mail: _____(of patient or family who is authorized to get your medical info. This is strictly for your medical information only. No solicitation.
Employer/School _____ Address: _____
Is the patient a minor? Yes No (If yes, the person accompanying the minor today is the guarantor)
GUARANTOR INFO:
Name _____ DOB _____ SS# _____
Address _____ Phone _____ Relationship _____

**** *WE NEED TO MAKE A COPY OF YOUR INSURANCE CARD(S) & DRIVER'S LICENSE* ****

Primary _____ Insurance Phone _____
Policy Holder's Name _____ DOB _____ SS# _____
ID# _____ Group #_____ Relationship to the insured _____
Employer _____ Employer Phone _____

Secondary_____ Insurance Phone _____
Policy Holder's Name _____ DOB _____ SS# _____
ID# _____ Group #_____ Relationship to the insured _____
Employer _____ Employer Phone _____

Tertiary _____ Insurance Phone _____
Policy Holder's Name _____ DOB _____ SS# _____
ID# _____ Group #_____ Relationship to the insured _____
Employer _____ Employer Phone _____

Disclosure of Interest:
Drs. Suresh and Kalpana Prasad have ownership interest in ORMC, and as a result, may financially benefit from the referral of services to ORMC in the form of increased dividends or distributions. Please let us know if you have any concerns regarding the financial relationship between Drs. Prasad and ORMC facility. You do have the option of using an alternative health care facility.

Assignment and Release:
I, the Undersigned, certify that I (or my dependent) have insurance coverage. I assign directly to SURESH PRASAD MD, PA; dba Permian Internal Medicine Associates (PIMA); all insurance benefits, if an otherwise payable to me for services rendered**. I understand that I am financially responsible for all charges whether or not paid by insurance**. I hereby authorize the doctor's office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Acknowledgement:
I acknowledge that a copy of the Office Procedure and Financial Policy, Release of Information, Litigation Policy, HIPPA policy, ACO participation set forth by PIMA has been made available to me. My signature below indicates that I agree to the terms provided.

X_____ _____
Signature of Patient or Guarantor Date