ASHOK J. KAR, M.D., INC.
ADULT UROLOGY & MALE INFERTILITY

PATIENT INFORMATION FORM

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow ☐ Minor ☐ Male/ ☐ Female

Name _____ (Last) _____ (First) _____ (M) Birth Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Social Security _____ Driver Licence _____

Emergency Contact _____ Relation _____ Phone _____

How Did U Hear About Us _____

Employment Information

Employer _____ Occupation _____

Address _____

Spouse Information

Name _____ Phone _____

Social Securtty# _____ Occupation _____

Insurance Information

How did you intend to pay? ☐ Cash ☐ Check ☐ Credit Card ☐ Insurance

Primary Insurance _____ Insured Name _____

Primary Insurance Address _____

Member Id # _____ Group # _____

Secondary Insurance _____ Insured Name _____

Secondary Insurance Address _____

Member Id # _____ Group # _____

Responsible Party

(If someone other than patient is resposible for payment please complete section)

Name _____ Relationship _____

Address _____

Phone _____ Birth Date _____ Social Securtty# _____

Authorization

(Please read before signing)

I request that all surgical or medical benefits, if any, otherwise payable to me for services rendered be paid to provider of service I understand that I remain financially responsible for all charges whether or not paid by insurance. I authorize the provider of service to release all information necessary to secure the payment of benefits. I also consent to the examination and/or treatment of myself and all minor children listed above by physicians, physician's assistant and other medical personnel.

Signature: _____ Date: _____

1310 W. STEWART DRIVE, # 402 ORANGE, CA 92868 TEL: (714)628-1341 FAX: (714)628-1345