ASHOK K. NARANG, M.D., PA
Ambulatory Care Center of Harford County
520 Upper Chesapeake Drive, Suite 308
Bel Air, Maryland 21014
443-643-4700

HARFORD ENDOSCOPY CENTER
2 North Avenue, Suite 102
Bel Air, Maryland 21014
410-838-6345
www.harfordendoscopy.com

PATIENT INFORMATION SHEET

NAME_____ SS #_____-_____-_____
LAST FIRST MI

ADDRESS_____ APT_____ DATE OF BIRTH _____-_____-_____

CITY_____ STATE_____ ZIP CODE_____ MARITAL STATUS: ☐ S ☐ M ☐ D ☐ W

HOME PHONE_____ WORK PHONE_____

EMPLOYER _____ SEX: ☐ Male ☐ Female
(If retired-give name of company)

ADDRESS_____ DRUG ALLERGIES: _____

REFERRING PHYSICIAN_____

ADDRESS / PHONE_____

WHOM TO NOTIFY IN CASE OF EMERGENCY

NAME_____ RELATIONSHIP_____

ADDRESS_____ HOME PHONE_____

CITY_____ STATE_____ ZIP CODE_____ WORK PHONE_____

Please Check off the following. This information is requested by the Department of Health and Mental Hygiene, for Statistical reporting purposes only.
Your response is appreciated. **ETHNICITY**

☐ 1. African American ☐ 2. American Indian/Eskimo ☐ 3. Asian ☐ 4. Hispanic ☐ Pacific Islanders ☐ 6. Caucasian ☐ 7. Other

PRIMARY INSURANCE

COMPANY_____ ***POLICY HOLDER'S***

ADDRESS_____ NAME_____ SS #_____-_____-_____

_____ DATE OF BIRTH_____ POLICY#_____

PHONE_____ EMPLOYER_____ GROUP #_____

SECONDARY INSURANCE

COMPANY_____ ***POLICY HOLDER'S***

ADDRESS_____ NAME_____ SS #_____-_____-_____

_____ DATE OF BIRTH_____ POLICY#_____

PHONE_____ EMPLOYER_____ GROUP #_____

DISCLOSURE AGREEMENT

I have been informed by the physician and Center that the physician who is rendering services has an ownership interest in the above referenced facility. The physician has given me the option to be treated at another facility, which I have declined. I wish to be treated at the above referenced facility.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize release of any medical information necessary to process any insurance claims and I authorize payment of medical benefits directly to ASHOK K. NARANG, M.D., P.A. / HARFORD ENDOSCOPY CENTER for myself or my dependents. I understand that I am responsible for any Deductibles, Co-insurances, Co-pays, or other amounts not covered by my insurance companies. If a referral is required and is not presented at the time of service, service will be denied until the referral is obtained.

DATE_____ SIGNATURE_____