Uma Murthy, MD
COLUMBIA MEDICAL ASSOCIATES
8808 Centre Park Dr., Suite 206
Columbia, MD 21045

Patient's Last Name: ________________________________ First Name: ___________________________ MI: ______

Address: ____

City: __________________________ State: ___________________ Zip Code: _________________________

Birth Date: _________________________ Sex (M/F): _____________ Marital Status: _____ S M D W Separated

Home Phone: ___________________________________ Social Sec #: _______________________________

Cell Phone / Best Number To Reach You: ____

Your e-mail address: ____

Emergency Contact: _____________________________ Phone #: _________________________________

= = = = Primary Insurance Coverage = = = = = = = = = = = = = = = Secondary Insurance Coverage = ========= = =

Insurance Name: __________________________________

Insured Name: ___________________________________

Relationship: _________________ DOB: ______________

Member ID #: ____________________________________

Copay: ____

Group #: ____

Employer: ____

Insurance Name: ______________________ _______

Insured Name: ________________________ _______

Relationship: __________________ DOB: ________

Member ID #: _______________________________

Copay:_____________________________________

Group #: ___________________________________

Employer: __________________________________

=========== Guarantor Information (must fill in for all patients 17 years and younger) ======================

Guarantor Name: ____ Relationship: _________________

Address: _____________________________________ City: ____________________ State: _______ Zip: ______

DOB: __________________________ Social Sec #: __________________________ Phone #: ______________

PATIENT'S AUTHORIZATION:

I authorize Dr. Uma Murthy to apply for benefits on my behalf for services rendered by her. I request payment from my insurance company be made directly to Dr. Uma Murthy. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in the place of the original. This authorization may be revoked, by me, at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

____ _________________________

Patient or Guarantor Signature Date

Uma Murthy, MD

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MEDICAL INFORMATION

Patient's Name: _________________________________ Age: _________________ Date of Birth: ________________________

Are you presently on any medications? _______ List Medications: ____

____

Allergies: ____

Check if you have ever had: (Explain under remarks)

( ) Accidents	( ) Received Disability/Workers Comp	( ) Snoring	( ) Sleep disturbance
( ) Diabetes	( ) Backaches, Back Strains	( ) Tuberculosis	( ) Fainting spells
( ) Epilepsy	( ) Frequent Headaches	( ) Heart Trouble	( ) Blood Spitting
( ) Ulcer	( ) Venereal Disease	( ) Rheumatism	( ) Frequent Colds
( ) Dermatitis	( ) High Blood Pressure	( ) Asthma	( ) Dizziness
( ) Hernia	( ) Paralysis	( ) Nervous Breakdown	( ) Scarlet Fever
( ) Arthritis	( ) Severe monthly cramps – Female	( ) Pleurisy	( ) Excessive Bleeding
( ) Pneumonia	( ) Prostate Problems – Male	( ) Rheumatic Fever	( ) Discharges
( ) Hay Fever	( ) Irregular Periods – Female	( ) Cancer	( ) Tumor
( ) Goiter	( ) Breast or Female Disorders	( ) Hemorrhoids	( ) Kidney Trouble
( ) Blurred Vision	( ) Exposure to unusual chemicals, etc	( ) Chronic Cough	( ) Difficulty Hearing
( ) Shortness of Breath	( ) Sores, bumps or swellings	( ) Stomach Trouble	( ) Chest Pain
( ) Urinary Frequency	( ) Abdominal Pain, nausea, vomiting	( ) Bruise easily	( ) Anemia
( ) Blood in urine	( ) Change in bowel habits	( ) Drug Addiction	

Remarks: ____

Have you ever been hospitalized? ____

Did you have surgery? ____

Do you smoke? _______________________________________ Do you drink alcohol? _____________________________

Do you exercise? _________ How Often: ____________________

Family History? Check if any family member has/had: ( ) Stroke ( ) High Cholesterol ( ) Diabetes

( ) Nervous or mental condition ( ) Cancer ( ) Heart Problem ( ) High Blood Pressure

<u>OFFICE USE ONLY</u>

Reviewed By: _______________________________________ Date: ___________________________________