Sundeep Mangla, M.D.
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NeuroInterventional MEDICINE

PATIENT INFORMATION

Name: _____Date of Birth: _____ Age: _____

Address: _____City: _____ State: _____ Zip: _____

Home: (_____) _____- _____ Cell: (_____) _____- _____ Work: (_____) _____- _____ Ext: _____

Email Address: _____ Sex: □ M □ F - Social Security #: ____/____/_____

□ Single □ Married □ Widowed □ Separated □ Divorced

Occupation: _____Employer: _____

Employer's Address: _____City: _____ State: _____ Zip: _____

PHYSICIANS (REFERRAL AND PRIMARY)

Referred By: _____Speciality_____ Phone #: (___) ____- _____

Address: _____City: _____State: _____Zip: _____

Primary Physician: _____Speciality_____ Phone #: (___) ____- _____

Address: _____City: _____State: _____Zip: _____

PHARMACY

Preferred Pharmacy Name: _____ Phone #: (___) ____- _____

Pharmacy Address: _____ City: _____ State:_____ Zip: _____

Emergency Contact: _____)_____ Phone #: (___) ____- _____

Relationship:_____

INSURANCE INFORMATION

Primary Insurance: _____

Policy Holder's Name: _____ ID #: _____

Policy Holder's Birth Date: _____Policy Holder's SS #: _____-_____-_____ Group #: _____

Secondary Insurance: _____

Policy Holder's Name: _____ ID #: _____

Policy Holder's Birth Date: _____Policy Holder's SS #: _____-_____-_____ Group #: _____

PATIENT COMMUNICATION CONSENT FORM

Patient Name: _____**Date of Birth:** _____

I agree to allow Dr. Sundeep Mangla M.D. DBA Neurointerventional Medicine PLLC to contact me using the following methods regarding my personal health information, evaluation and treatment.

I authorize _____/ do not_____ authorize ***Dr. Sundeep Mangla M.D. DBA Neurointerventional Medicine PLLC*** to leave messages for me when I am unavailable as indicated below.

Check to confirm approved Method:

	Phone #	
Home Phone:	(____) _____- _____	□ Yes □ No
Cell Phone	(____) _____- _____	□ Yes □ No
Work Phone	(____) _____- _____	□ Yes □ No
Alt. Phone:	(____) _____- _____	□ Yes □ No
Email: _____@_____		□ Yes □ No
Mail Address: _____		□ Yes □ No

City_____State_____Zip_____

I authorize ***Dr. Sundeep Mangla M.D. DBA Neurointerventional Medicine PLLC*** and medical staff to discuss my personal health information with the individuals listed below. I understand that by leaving spaces blank, I am indicating my choice that I do not want my information shared with or released to anyone else.

Name & Relationship to Patient

Emergency Contact: Name: _____ Phone #: (____) _____- _____

Relationship: _____

Additional Contact: Name: _____ Phone #: (____) _____- _____

Relationship: _____

Additional Contact: Name: _____ Phone #: (____) _____- _____

Relationship: _____

By my signature below, I hereby acknowledge that I have read and understand the information provided on this ***Consent Form***. I understand the risk associated with different methods of communication, especially email, and consent to communications outlined in this consent.

Patient Name Printed: _____

Patient/Authorized Signature: _____Date_____

Relationship to Patient (Self or POA): _____