Shashi Dharma, M.D., F.A.C.S.
Diplomate, American Board of Ophthalmology
6500 Sierra Dr. Ste. #170 Irving. TX 75039 (P) 972 331-1590 (F) 972 331-1599
3504 Corinth Pkwy Ste. # 140 Corinth, TX 76208 (P) 940 269-4230

NEW PATIENT INFORMATION

PATIENT NAME:
(Last Name) (First Name) (MI)

Email:

Home Phone:

Cell/Alternate Phone:

Sex: ____Male ____Female

Birth Date: Age:

SS#

Home Address: Stress Address

APT# City

ST Zip

Martial Status: ____Married ____Single ____Divorced

Reason For Visit:

Primary Care

Physician:
Phone:

Referring Physician:
Phone:

Insurance Provider:

Insurance ID#

Insurance Group #

Insurance Provider Phone #

Employer:

Employer Address:

Work Phone:

____Full-Time ____Part-Time ____Retired

Person to be reached in
case of emergency:

Relation:

Phone:

I hereby authorize Dr. Shashi Dharma's office to release written or verbal information to my doctor or insurance carrier (if the information is requested). In consideration of services rendered, I hereby assign to Dr. Dharma benefit payments due from my insurance company for medical expenses incurred which are payable to me.

I have been informed of or received a copy of the "Notice of Privacy Practices."

Payment is due at time of service! This includes all copays, deductibles, and any other non-covered items.

**A $25 fee will be charged for all "NO SHOW" appointments
not canceled at least 24 hours in advance.**

I accept the above terms and are responsible of any incurring charges.