Prema Kothandaraman M.D. F.A.C.O.G
The OB/Gyn Place

Please print ALL requested information

Last Name _____ M.I ____
First Name _____
Mailing Addr. Line 1 _____
Line 2 _____
City _____
State _____ Zip _____
Home Phone _____
Cell Phone _____
Work Phone _____
eMail _____
Responsible Party: ☐ Self ☐ Other
If Other, Enter Name _____
Address _____
Phone _____

Primary Care Physician _____
Referring Physician _____
Date of Birth ____/____/_____
Sex ☐ Male ☐ Female
Marital Status ☐ Single ☐ Married ☐ Separated
Social Security _____/____/_____
Emergency Contact Name _____
Address _____
City, State, Zip _____
Phone (Home) _____
Phone (Cell) _____

Insurance Carrier Name : _____ ☐ Primary ☐ Secondary
Subscriber No: _____ Co-Pay $ _____
Insured's Name _____ Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child
Group No _____ Group Name _____
Medi-Cal ID Number _____

Insurance Carrier Name : _____ ☐ Primary ☐ Secondary
Subscriber No: _____ Co-Pay $ _____
Insured's Name _____ Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child
Group No _____ Group Name _____
Medi-Cal ID Number _____

Pharmacy where you normally get your medicine: _____
Pharmacy Address _____, City _____ State _____ ZIP _____
Pharmacy Phone _____ Pharmacy Fax _____

Street Address ☐ Same as mailing address.
Street _____
City _____ State ____ Zip _____

Employer Name _____
Address _____
City _____ State ____ Zip _____
Phone _____

How did you hear about us? ☐ Friend ☐ Insurance ☐ Internet ☐ Physician _____