Ranjit S. Grewal, M.D.,PA

10726 Huffmeister Rd Houston, Tx 77065
Phone: 281-477-0525
Fax: 281-477-0526

Patient Information:

Name:_____
First **Middle** **Last**

DOB:_____**SS#**_____**Sex: M / F EMAIL:**_____

Address:_____
Street **City** **State** **Zip**

Cell:_____**Home:**_____**Work:**_____

Race:_____**Ethnicity:**_____**Primary Language:**_____

Pharmacy Name:_____**Pharmacy Phone:**_____

Insurance Information:_____
Insurance Company **PO BOX**

Member ID:_____**Group#**_____

Policy Holder_____
Name **DOB** **SS#**

Secondary Insurance:_____
Insurance Company **PO BOX**

Member ID:_____**Group#**_____
Emergency Contact:_____**(relation)**_____**Phone:**_____

I authorize the release of Medical Information to:_____
I hereby assign, transfer, and set over to Ranjit S. Grewal, MD, PA all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges wether or not they are covered by insurance.

Patient's Signature_____**Date:**_____