TJ Rai, M.D.

THERAPY | MEDICATION | WELLNESS

PATIENT INFORMATION Date: _____ /_____ /_____

Patient Name: _____ ❑ M ❑ F Birthdate: _____ /_____ /_____
FIRST MIDDLE LAST

Marital Status: ❑ S ❑ M ❑ D ❑ W Occupation:_____ SSN: _____-_____-_____

Home Address: _____
STREET CITY STATE ZIP

Tel: _____ Work: _____ Mobile: _____ Email: _____

PAYMENT INFORMATION (Information about the person financially responsible for treatment)

V / MC / AmEx / Disc #: _____ Exp Date: _____
MO-YR

Name as it appears on Card: _____ ❑ M ❑ F Birthdate: _____ /_____ /_____
FIRST MIDDLE INITIAL LAST

Card Billing Address: _____
STREET CITY STATE ZIP

Relationship to patient: _____ Occupation: _____ SSN: _____-_____-_____

Employer: _____ Job Title: _____
COMPANY NAME

Work Address: _____
STREET CITY STATE ZIP

Tel: _____ Work: _____ Mobile: _____ Email: _____

SIGNIFICANT OTHER (SECOND PARENT / SPOUSE / DOMESTIC PARTNER) INFORMATION

Name: _____ ❑ M ❑ F Birthdate: _____ /_____ /_____
FIRST MIDDLE INITIAL LAST

Relationship to patient: _____ Occupation: _____ SSN: _____-_____-_____

Home Address: _____
STREET CITY STATE ZIP

Tel: _____ Work: _____ Mobile: _____ Email: _____

EMERGENCY CONTACT INFORMATION

Primary Care Physician: _____ Tel: _____

Emergency Contact Name: _____ Relationship: _____

Tel: _____ Work: _____ Mobile: _____ Email: _____

AGREEMENT: By signing below I authorize TJ Rai, M.D. to charge the credit/debit card listed above for routine appointments (unless I pay by check or cash at the time of the appointment) and also for any appointments that are canceled with less than 2 BUSINESS DAYS NOTICE.

PRINT NAME AND SIGN HERE: _____