## South Florida Surgical Specialists, LLC Interventional Pain and Wellness Center Kush Tripathi, MD

Patient:		<del></del>
Last Name	First	M.I
Address:		
City	State	Zip Code
Home phone:	SS#:	
Date of birth:	Age:	
Patient's Employer:	Occupatio	on:
City of Employment:	Phone #: _	
Spouse's Name: Spouse's DOB		DOB:
Spouse's Employer: Phone #:		
	Phone #:	
Referred by: Primary Physician:		Physician:
Primary Insurance:	ID#:	Group:
Address:		
****If you are NOT the primary p	oolicy cardholder, WE NEED	the following information****
		: SSN:
Secondary Insurance:	ID#:	Group:
*I give permission to Dr. Kush Tri	pathi to administer medical tr	reatment to me and authorize the release of all
medical information necessary for Sign:	my treatment.	
<u> </u>	directly to South Florida Surg	essary to process an insurance claim. I authorize gical Specialists, LLC. I authorize photocopies of
Sign:	Date:	
	<b>E</b>	a Internet by South Florida Surgical Specialists, Email Address:
ayment is expected when services	are renuereu	