PATIENT REGISTRATION UPDATE

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- ☐ Hemang C. Patel, M.D.
- ☐ Ankur M. Shah, M.D.
- ☐ Milan Shah, M.D.

Patient Name: _____ **Date:** _____

Date of Birth: _____ Age: _____ Social Security #: _____

Current Address: _____ Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Home Ph.: (____) _____ Work Ph.: (____) _____ Mobile: (____) _____

Email: _____ ☐ or Text Appointment Notice *(optional)* ☐

Preferred Method of Phone Contact: ☐ Mobile ☐ Home ☐ Work *(please check one)*

Employer Name: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

MEDICAL INSURANCE INFORMATION

Primary Insurance Carrier: _____

Secondary Insurance Carrier: _____

We will need to make a copy of your current insurance cards.

How is the "Insured" party related: ☐ Self ☐ Guarantor ☐ Spouse

Spouse's Name: _____

Date of Birth: _____ Social Security #: _____

Does your insurance company require a formal authorization or referral form from a Primary Care Physician for our services? ☐ Yes ☐ No If yes, Physician's Name _____

PRIMARY CARE PHYSICIAN

Have you changed Primary Care Physician? ☐ Yes ☐ No

If yes, Physician's Name: _____ Phone: (____) _____

Primary Care Physician's Address Care _____ Physician' _____

City: _____ State: _____ Zip: _____

Preferred Pharmacy Name: _____ Pharmacy _____ N _____

Preferred Pharmacy Address: _____ Pharmacy _____ Address: _____

City: _____ State: _____ Zip: _____

PATIENT REGISTRATION UPDATE CONTINUED

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

Address (if different from patient): _____

City: _____ State: _____ Zip: _____

Primary Ph.: (____) _____ Alternate Ph.: (____) _____

RELEASE OF INFORMATION

I authorize the release of any medical information necessary to my insurance company relative to services rendered. I further authorize the Payment of Benefits to the Physician for services rendered. I understand that this authorization remains valid unless/until I revoke it myself.

X _____ Date: _____

Signature of Patient or Legal Guardian

FINANCIAL RESPONSIBILITY STATEMENT

I acknowledge responsibility for payment of all medical fees regardless of insurance I may have to assist me in this responsibility. The only exception will be charges for services covered under a contractual agreement that has been entered into between my physician and an insurance company, or other third party payor. If for any reason my account should become delinquent, I am liable to pay all collection and legal fees.

X _____ Date: _____

Signature of Patient or Legal Guardian

MEDICARE AUTHORIZATION

I request the payment of appropriate, authorized Medicare benefits be made on my behalf to my physician/provider to me by this physician/provider. Additionally, I authorize my medical provider to release any information about me to the Health Care Financing Administration, Centers for Medicare/ Medicaid, and/or their agents, that might be needed to determine any benefits payable for the services furnished. I also permit a copy of this authorization to be used in place of the original.

X _____ Date: _____

Signature of Patient or Legal Guardian

☐ NOT APPLICABLE

PATIENT'S THIRD PARTY PAYER AND/OR MEDICARE SUPPLEMENT AUTHORIZATION

I request the payment of appropriate, authorized benefits be made on my behalf to my physician/ provider for any services furnished to me by this physician/provider. Additionally, I authorize my medical provider to release any information about me to the insurance carrier and/or third party medical claims administrator, covering me at the time medical services provided, that might be needed to determine any benefits payable for services furnished. I will also permit a copy of this authorization to be used in place of the original.

X _____ Date: _____

Signature of Patient or Legal Guardian

☐ NOT APPLICABLE