PATEL HEALTHCARE LLC
PATIENT REGISTRATION FORM

PLEASE BE INFORMED THAT EVERY INSURANCE IS DIFFERENT. IN ORDER TO HAVE A SMOOTH PROCESSING AND HANDELING OF YOUR ACCOUNT, WE NEED TO HAVE THE FOLLOWING INFORMATION.

PATIENT LAST NAME: _____ **FIRST NAME:** _____ **MI:** _____
DATE OF BIRTH: _____ **SOCIAL SECURITY #:** _____ **GENDER:** _____
ADDRESS: _____
CITY: _____ **STATE:** _____ **ZIP:** _____
HOME PHONE: _____ **CELL:** _____ **WORK PHONE:** _____
PHARMACY NAME: _____ **CITY:** _____
PRIMARY LANGUAGE SPOKEN AT HOME: _____
MARITAL STATUS: [ ] SINGLE [ ] MARRIED [ ] DIVORCED [ ] OTHER: _____
EMERGENCY CONTACT: LAST NAME: _____ **FIRST NAME:** _____
PHONE: _____ **RELATIONSHIP TO PATIENT:** _____
EMPLOYER NAME: _____ **TELEPHONE NUMBER:** _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____ **SUBSCRIBER'S NAME:** _____
PRIMARY INSURANCE POLICY NUMBER: _____ **INSURANCE GROUP #:** _____
PRIMARY INSURANCE CLAIM MAILING ADDRESS: _____
PATIENT'S RELATIONSHIP: SELF/SPOUSE/OTHER _____ **CO-PAYMENT:** _____

SECONDARY INSURANCE COMPANY NAME: _____ **SUBSCRIBER'S NAME:** _____
SECONDARY INSURANCE POLICY NUMBER: _____ **INSURANCE GROUP #:** _____
SECONDARYU INSURANCE CLAIM MAILING ADDRESS: _____
PATIENT'S RELATIONSHIP: SELF/SPOUSE/OTHER _____ **CO-PAYMENT:**_____

WHO REFERRED YOU TO OUR OFFICE?
_____

IT IS YOUR RESPONSIBILITY TO PROVIDE US WITH CORRECT AND COMPLETE INFORMATION FOR THE ABOVE ITEMS. THE AMOUNTS THAT ARE NOT COVERED BY YOUR INSURANCE AND THAT ARE DUE TO THE OFFICE ARE PAYABLE AT THE TIME SERVICES ARE RENDERED. IN ORDER TO MAINTAIN QUALITY CARE MINIMAL COST, WE HOPE YOU WILL UNDERSTAND THE IMPORTANCE OF FOLLOWING THE ABOVE REQUEST. IT IS YOUR RESPONSIBILITY TO MAKE FOLLOW UP OFFICE VISIT TO DISCUSS ANY TEST RESULTS OR CONSULTATIONS THAT ARE ADVISED BY DOCTOR OF PATEL HEALTHCARE, LLC. ALSO YOU ARE RESPONSIBLE TO KEEP UP YOUR APPOINTMENT AS ADVISED.

WE NEED COPIES OF:

1. YOUR INSURANCE CARD(S)
2. YOUR DRIVER'S LICENSE/STATE ISSUED PICTURE ID OR PASSPORT
3. SOCIAL SECURITY CARD

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ALL INSURANCE CLAMS AND REQUEST PAYMENTS OF BENEFITS TO PATEL HEALTHCARE, LLC FOR ALL SERVICES RENDERS.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE