Patient Registration Information

Please PRINT AND complete ALL sections below

How did you hear about Dr. B. Patel - ☐ **Doctor Name:**_____ ☐ **Walk-in** ☐ **Friend or relative** ☐ **Other** _____

PATIENT'S PERSONAL INFORMATION

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Sex:** ☐ Male ☐ Female

Name: _____ (LAST NAME) _____ (FIRST NAME) _____ (MIDDLE)

Date of Birth: _____ / _____ / _____ Social Security #: _____ - _____ - _____

Home Phone: (_____) _____ Cell Phone: (_____) _____ Work Phone: (_____) _____

Address: _____ City: _____ State: ____ Zip: _____

POLICY HOLDER / RESPONSIBLE PARTY

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Name: _____ (LAST NAME) _____ (FIRST NAME) _____ (MIDDLE)

Date of Birth: _____ / _____ / _____ Social Security #: _____ - _____ - _____

Home Phone: (_____) _____ Cell Phone: (_____) _____ Work Phone: (_____) _____

Address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____

PATIENT'S INSURANCE INFORMATION

Please present insurance cards to receptionist.

PRIMARY Insurance Name: _____

Name of insured: _____ Date of Birth: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: _____ Group #: _____ Copay: $ _____

SECONDARY Insurance Name: _____

Name of insured: _____ Date of Birth: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: _____ Group #: _____ Copay: $ _____

NUMBERS WE MAY LEAVE MESSAGES

May we leave messages at the numbers listed above _____ Yes or _____ No

If NO which number may we leave messages at: _____

PHARMACY INFORMATION

WE DO NOT MAIL OR FAX PRESCRIPTIONS TO MAIL-ORDER PHARMACIES. You are responsible for mailing/faxing.

Pharmacy Name: _____

Address: _____ City: _____ State: ____ Zip: _____

EMERGENCY CONTACT

I hereby grant this person to have access to my protected health information.(Please list other phones numbers than listed above)

Name: _____ Relationship: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

EMPLOYMENT INFORMATION

☐ Full-Time ☐ Part-Time ☐ Retired ☐ Self Employed ☐ Unemployed

Employer Name: _____ Position : _____

Address: _____ City: _____ State: ____ Zip: _____

Work Phone: (_____) _____ EXT: _____

Payment Policy:

I hereby give authorization for payment of insurance benefits to be made directly to Clarksville Internal Medicine PLC –Bharat Patel M.D., and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all contingent fees to collection agencies of not less than thirty-five percent, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I understand that co-pays, co-insurances, deductibles & all past due balances are due at time of service. Returned checks will be debited to your account

Cancellation Policy: Patients are expected to notify the office at least 24 hours prior to scheduled appt. times. Failure to notify us in advance can result in a no show charge to your account. Three non-notified missed appointments may result in dismissal from the practice.

I further agree that a photocopy of this agreement shall be as valid as the original.

Notice of Privacy Practices (HIPAA): I HAVE READ, UNDERSTAND AND HAVE ACCESS TO A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICE AND OFFICE POLIICES.

Date: _____ Signature: _____