Patient Registration Information

Please PRINT AND complete ALL sections below

How did you hear about Dr. B. Patel/Clinic - ☐ **Friend/relative** ☐ **Internet** ☐ **Insurance** ☐ **Other** _____

PATIENT'S PERSONAL INFORMATION

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

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

DATE OF BIRTH:____ _____/_____/_____ **Social Security # :** _____ **Gender at Birth** ☐ Male or ☐ Female

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

Address: _____ City: _____ State: _____ Zip Code:_____

POLICY HOLDER / RESPONSIBLE PARTY

Relationship to Patient: ☐ Self (see above) ☐ 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. (For Office use only: ☐ see scanned or copy of card)

PRIMARY Insurance Name:_____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Othe

Policy #: _____ Group #: _____

SECONDARY Insurance Name:_____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: _____ Group #: _____

PHARMACY INFORMATION

All prescriptions will be sent electronically ; Any controlled substances will be sent to your local pharmacy ONLY

Local Pharmacy Name / Address:_____

Mail Order Pharmacy Name : _____

EMERGENCY CONTACT

(Please list a different phone number than one 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: _____

EMAIL

For appointment reminders and patient portal - Patient Portal is administered by Updox.

EMAIL Address:_____

Updox employs several tactics to protect information from theft, misuse, unauthorized access, disclosure, alteration, and destruction. During transmission, information is encrypted and hashed to prevent unauthorized access or tampering.

Appointment 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 and all identification cards shall be as valid as the original. I have reviewed and understand and agree to all office polices set by Clarksville Internal Medicine.

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:** _____