HIMANSHU P. PARIKH, M.D.P.C.

NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION

NAME: _____

DATE OF BIRTH: _____ SEX: ☐ MALE ☐ FEMALE

ADDRESS: _____

STREET **APT#** CITY STATE ZIP CODE

PHONE NUMBER, CHECK PREFERRED

	CELL:
	HOME:
	WORK:

SOCIAL SECURITY: _____

EMAIL:

_____

*Must list e-mail to access Patient Portal

Preferred Pharmacy: _____

Address: _____ **Phone:**_____

Please indicate if it is okay for us to leave a confidential voice mail that may include test results, prescription information, or any other medical information pertaining to your health. This will reduce the need for you to return our call if you do not have any additional questions. This should be a phone number where only you, or anyone that you are comfortable with hearing your medical information, have access to. **YES_____ NO_____**

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORED

EMPLOYMENT STATUS: ☐ F/T ☐ P/T ☐ STUDENT ☐ UNEMPLOYED ☐ DISABLED ☐ RETIRED

EDUCATION: ☐ ELEMENTARY ☐ HIGH SCHOOL ☐ UNDERGRADUATE ☐ GRADUATE ☐ MASTERS ☐ DOCORATE

ETHNICITY: ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐ UNKNOWN/DECLINE

RACE: ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ NATIVE HAWIAAN OR OTHER PACIFIC ISLANDER ☐ OTHER RACE ☐ WHITE ☐ UNKNOWN OR DECLINE

PREFERRED LANGUAGE: ☐ ENGLISH ☐ SPANISH OR CASTILIAN ☐ OTHER

PRIMARY INSURANCE

INSURANCE COMPANY: _____

POLICY ID #: _____GROUP: _____

IF POLICY HOLDER IS OTHER THAN SELF, COMPLETE THE SECTION BELOW.

POLICY HOLDER NAME: _____ RELATION TO PATIENT: _____

DATE OF BIRTH: _____ SEX: ☐ M ☐ F SOCIAL SECURITY #: _____

SECONDARY INSURANCE

INSURANCE COMPANY: _____

POLICY ID #: _____ GROUP #: _____

POLICY HOLDER NAME: _____

IF POLICY HOLDER IS OTHER THAN SELF, COMPLETE THE SECTION BELOW.

POLICY HOLDER NAME: _____ RELATION TO PATIENT: _____

DATE OF BIRTH: _____ SEX: ☐ M ☐ F SOCIAL SECURITY #: _____

ALLERGY ALERT

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ YES ☐ NO ☐ I DON'T KNOW

IF YES, LIST MEDICATIONS: _____

IS YOUR CONDITION RELATED TO EMPLOYMENT? ☐ YES ☐ NO

IF YES, COMPLETE THE SECTION BELOW.

EMPLOYER'S NAME: _____ EMPLOYER'S PHONE #: _____

EMPLOYER'S ADDRESS: _____

IS YOUR CONDITION RELATED TO AN AUTO ACCIDENT? ☐ YES ☐ NO

IF YES, COMPLETE THE SECTION BELOW.

NAME OF AUTO INSURANCE: _____DATE OF ACCIDENT: _____

This office does not participate in any "third party billing."

The patient is fully responsible for payment of all charges at the time of service.

EMERGENCY CONTACT

NAME: _____ PHONE #: _____

RELATIONSHIP TO PATIENT: _____

HOW DID YOU HEAR OF OUR PRACTICE? _____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

By signing below, I, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medical services, surgical or diagnostic procedures, including lab and radiographic studies, as ordered by this office and its healthcare provider.

I hereby authorize Dr. Himanshu Parikh, M.D. to release any information acquired during my examination or treatment to specific insurance carriers, third party payers, or others involved in the processing and collecting of claims, via fax or other secure electronic means, in accordance with the HIPAA Patient Confidentially Act of 1996.

I hereby agree to pay all the charges submitted by this office during treatment. If there is insurance coverage with a managed care organization, with which this office has a contractual agreement, I agree to pay all applicable co-payments, co-insurance, and deductibles, which arise during treatment. If I agree to a treatment which is not considered to be a covered service by my insurer and/or third-party insurer or other payor, I understand that I am responsible for that charge as well. I further understand that if I do not show for an appointment or do not give 24 hours' notice when canceling an appointment I may be responsible for a missed appointment charge of $25.00.

SIGNITURE: _____ **DATE:** _____