LAL BHAGCHANDANI M D P A

Patient Registration Form

(Please Print)

Today's Date _____/_____/_____ **PRIMARY MD**_____

PATIENT INFORMATION

Patient's Last Name	First	Middle	☐Mr. ☐Miss ☐Mrs. ☐Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Social Security Number / /	Birth Date - -	Sex ❑ M ❑ F	Race	Language:

Email Address	Home Phone No. ( )	Cell Phone No. ( )

Street Address City State ZIP Code

Occupation	Employer	Employer Phone No. ( )

Chose Clinic Because / Referred to Clinic by (Please check one box) ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other _____

PHARMACY INFORMATION (WE MUST HAVE THIS INFORMATION FOR ANY PRESCRIPTIONS WRITTEN AT YOUR APPOINTMENT)

Name of Local Pharmacy you use:_____ Phone Number_____

City_____ Zip Code_____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )

Occupation	Employer	Employer Address	Employer Phone No. ( )

Is this patient covered by insurance? ❑ Yes ❑ No

PRIMARY INSURANCE ❑ **SECONDARY**

IN CASE OF EMERGENCY

Name of Local Friend or Relative in case of an emergency	Relationship to Patient	Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Lal Bhagchandani, M.D., P.A. or insurance company to release any information required to process my claims.

X_____

PATIENT/GUARDIAN SIGNATURE DATE