

PATIENT REGISTRATION FORM

Please Print Legibly. All fields must be completed. Please put "n/a" (not applicable) or "NWTP" (not willing to provide) instead of leaving blank. Thank you for your cooperation.

Bakul T. Roy, MD

PATIENT INFORMATION

Last Name:	First Name:	Middle Initial:	<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital Status:
			<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/>
			<input type="checkbox"/> Dr.		Separated <input type="checkbox"/> Divorced <input type="checkbox"/>
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	Former/Maiden Name (if any):			Birth Date:
					Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Physical Street Address:				Home Phone Number:	
City, State, Zip:				Cell Phone Number:	
Occupation:	Employer:			Work Phone Number:	
Email Address:				Social Security Number:	
Preferred Pharmacy (Name & Location):					
Who may we contact in case of emergency?				Relationship to you:	
Emergency Contact Home Phone Number:	Emergency Contact Cell Phone Number:			Emergency Contact Work phone number:	
How did you hear about our office?			Preferred Appointment time(s): No Preference <input type="checkbox"/>		
			Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thu <input type="checkbox"/> Fri <input type="checkbox"/>		
			Morning <input type="checkbox"/> Afternoon <input type="checkbox"/>		

BILLING INFORMATION

Person Responsible for Bill: <input type="checkbox"/> Self (skip to Primary Insurance Information Section) <input type="checkbox"/> Other:	Address:	Home Phone Number:
Relationship to Patient:	City, State, Zip:	Cell Phone Number:
Date of Birth:	Social Security Number:	Work Phone Number:

PRIMARY INSURANCE INFORMATION

Insurance Company:			<input type="checkbox"/> PPO <input type="checkbox"/> HMO, please specify: <input type="checkbox"/> Hill Physicians <input type="checkbox"/> John Muir Medical
Is this an employer plan? If so, name of employer:			<input type="checkbox"/> None (personal policy)
Subscriber Name:	Subscriber Social Security Number:	Birth Date:	Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other (specify):
Group Number:	Subscriber/Member/Policy ID:	Effective Date:	Copay (PCP)/Deductible:

SECONDARY INSURANCE INFORMATION

Insurance Company: <input type="checkbox"/> None (Skip to Financial & Office Policies Section)			<input type="checkbox"/> PPO <input type="checkbox"/> HMO, please specify: <input type="checkbox"/> Hill Physicians <input type="checkbox"/> John Muir Medical
Is this an employer plan? If so, name of employer:			<input type="checkbox"/> None (personal policy)
Subscriber Name:	Subscriber Social Security Number:	Birth Date:	Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other (specify):

Group Number:	Subscriber/Member/Policy ID:	Effective Date:	Copay (PCP)/Deductible:
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PATIENT REGISTRATION FORM
(Continued)

FINANCIAL & OFFICE POLICIES

Please check each box to indicate that you have read each statement.

- I authorize my insurance carrier, attorney, or any third-party payor to pay directly to **Bakul T. Roy, MD/Roy Medical Associates)** for payment of medical benefits for services rendered.
- I authorize the release of any information required to process my claims or as required by law.
- I understand that I am financially responsible for all services rendered.
- I have had a chance to review the **Notice of Privacy Practices**. I understand that this practice reserves the right to change the terms of the Notice of Privacy Practices. If changes to the policy occur, I will be provided with a revised Notice of Privacy Practices upon request.

The information I have provided on this Registration Form is true to the best of my knowledge.

X

Patient Signature

Date

Print Patient Name:

I acknowledge that I have received, read, understand, and signed the Financial and Office Policies of Bakul T. Roy, MD/ Roy Medical Associates.

X

Patient Signature

Date

FOR OFFICE USE ONLY

_____ Insurance Card Scanned to File

_____ HIPAA Notice Completed

_____ Insurance Verified

_____ Driver's License Verified

_____ Demographics Entered

_____ Scanned