Maitri Patel MD
Internal Medicine
Board Certified

PRUDENTMD

Anneta Golubchik MD
Infectious Disease
Board Certified

REGISTRATION FORM

PATIENT INFORMATION

Patient's last name: First:		Social Security No:		
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Birth date: / /	Age:	Gender: ❑ M ❑ F
Home street address:		City:	State :	Zip:
Home Phone No:	Mobile Phone No:		Email:	
Work Phone No:	Preferred method of communication: ❑Home phone ❑Mobile phone		Ethnicity: ❑Non-Hispanic ❑Hispanic ❑Other:	
Preferred Language: ❑English ❑Gujarati ❑Hindi ❑Spanish ❑Other:	Race: ❑Asian ❑African American ❑Caucasian or European American ❑ Native American ❑Other:			
Referred to clinic by: ❑Dr.	❑ Family / Friend :		❑Other :	

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

❑ Self pay (I do not have insurance)

❑ Insurance name (Primary)	Insurance Policy holder's name:	
Policy #:	Policy holder's Birth Date:	Policy holder's SSN:
Patient's relationship to subscriber (policy holder): ❑ Self ❑ Spouse ❑ Child ❑ Other:		
❑ Insurance name (if you have secondary insurance):	Insurance Policy holder's name:	
Policy #:	Policy holder's Birth Date:	Policy holder's SSN:
Patient's relationship to subscriber (policy holder): ❑ Self ❑ Spouse ❑ Child ❑ Other:		

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship:	Home Phone No:	Mobile 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 understand that I will be responsible to inform the office of any change in my demographic and insurance information. I understand that I have to pay previous balance prior to my next visit. I authorize doctors and staff of PrudentMD to release any information required to process my claims, for my care and for administrative and billing purpose. I also authorize PrudentMD to release my medical information to other physicians, pharmacies, labs, insurance companies, healthcare facility, Government for the purpose of care, administration or billing. I am aware that PrudentMD keeps electronic medical records by web based application and provides web based portal access to patients and I provide consent to it. I give consent to send me email reminders and or health education. I understand and agree to the office financial, ethical and privacy practices (visit prudentmd.com or ask office staff for a copy). I also understand that fees for medical visit and procedures may change anytime without notice.

Patient/Guardian signature:	Date