PAREKH MEDICAL CLINIC-REGISTRATION FORM

Patient Name: _______________________________ Social Security #:______ - ______ - __________

Date of Birth: _____ /______ /______ Sex: M/F (Circle one) Married/Singled/Divorced/Widow

Home Mailing Address: ____
(Street) **(City/State/Zip)**

Phone: (____) _____ - ______ (Home/Work/Mobile) Phone: (____) _____ - ______ (Home/Work/Mobile)

Email Address: __________________________________ Primary Physician: _____________________

Employer Name: _____________ Employer Phone: (____) _____ - ______ Occupation: _______________

Fluently Spoken Language: ________________ Race/Ethnicity: _________________________________

Pharmacy: __________________________ Who is your primary care giver: _________________________

List of any other doctors you see: (1) _______________________ (2) _______________________________

(3)____ (4) ____

What is your preferred way to be contacted: Phone Mail Email

Parent/ Person responsible for bill (Complete only if different from patient)

Guarantor Name: ____________________________________ Social Security #: _______ - _____ - _______

Relationship to Patient: (please check): ( ) **self,** ( ) **spouse, or** ( ) **parent** DOB: ____ / _____ /_______

Who to call for an emergency

Name: ________________________________Address: ____

Phone: (____) _____ - ______ (Home/Work/Mobile) Relationship: ________________________________

PRIMARY INSURANCE

Plan Name: ________________ I.D. Number: ______________________ Group Number: _____________

Card Holder's Name: ________________SSN #: ______ - ______- ______ Sex: ( ) M ( ) F

Card Holder's Date of Birth: _______/ _______/________ Relationship to Patient: _________________

SECONDARY INSURANCE

Plan Name: ________________ I.D. Number: ______________________ Group Number: _____________

Card Holder's Name: ________________SSN #: ______ - ______- ______ Sex: ( ) M ( ) F

Card Holder's Date of Birth: _______/ _______/________ Relationship to Patient: _________________