MITTAL
Gastroenterology & Rheumatology

7045 N Maple Ave Suite 101
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# REGISTRATION FORM

(Please Print)

Today's Date _____/_____/_____ Primary Care Physician_____

## PATIENT INFORMATION

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

| Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | (Former Name) | Birth Date / / | Age | Sex ❑ M ❑ F |
|---|---|---|---|---|---|

| Street Address | City | State | ZIP Code | Social Security | Home Phone No. ( ) |
|---|---|---|---|---|---|

| P.O. Box | City | State | ZIP Code |
|---|---|---|---|

| Occupation | Employer | Employer Phone No. ( ) |
|---|---|---|

Chose Office Because/Referred to Office by (Please check one box) ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital
❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other _____

Patient's Email Address: Other Family Members Seen Here:

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

| Person Responsible for Bill | Birth Date / / | Address (if different) | Home Phone No. |
|---|---|---|---|
| Is this person a patient here? | ❑ Yes ❑ No | | ( ) |

| Occupation | Employer | Employer Address | Employer Phone No. ( ) |
|---|---|---|---|

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

| Subscriber's Name | Subscriber's S.S. # | Birth Date / / | Group # | Policy # | Co-Payment $ |
|---|---|---|---|---|---|

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

| Name of Secondary Insurance (if applicable) | Subscriber's Name | Group # | Policy # |
|---|---|---|---|

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

## IN CASE OF EMERGENCY

| Name of Local Friend or Relative (not living at same address) | Relationship to Patient | Home Phone No. ( ) | Work Phone No. ( ) |
|---|---|---|---|

The above information is true to the best of my knowledge. I hereby give consent for medical or surgical treatment to Mittal Gastroenterology & Rheumatology team to care for myself or I am duly authorized by the patient as his/her general agent to give consent for such treatment. I authorize my insurance benefits be paid directly to the Dr. Vivek Mittal M.D. & Dr. Manisha Mittal M.D. Inc. I understand that I am financially responsible for any balance. I understand that if this or any other visit precedes the effective date of my insurance; or is not covered by my insurance, I will be held responsible for all fees incurred as a result of this and any subsequent visit. I also authorize Mittal Gastroenterology & Rheumatology or insurance company to release any information required to process my claims.

X _____

PATIENT/GUARDIAN SIGNATURE DATE PATIENT CELL PHONE NUMBER