Dr. Parag R. Patel, MD Patient Registration Form

PATIENT INFORMATION (please print)

□Dr □Miss □Mr. □Mrs. □Ms. □Sir.
Patient's Name:(Last)_____(First)_____(MI)____PreviousName_____
Address Line1_____
City_____ State_____ Zip_____
Home Phone_____ Cell No. _____ Work Phone _____Ext. _____
E-mail Address:_____
Date of Birth MM_____/DD_____/YYYY_____ Social Security Number _____-_____-_____
Race □American Indian or Alaska Native □Asian □ Native Hawaiian or Other Pacific Islander □Black or African American □White □Declined
Ethnicity □Hispanic or Latino □Not Hispanic or Latino □Declined
Language □English □Spanish □Indian □Japanese □ Chinese □Korean □French □German □Russian □Other
Marital Status □Married □Single □Divorced □Widowed □Legally Separated □ Partner
Sex □ F – Female □ M-Male
Emergency Contact Last Name_____ First Name _____
Phone Number _____
Emergency Contact Relationship to Patient _____ □Guardian
Address Line 1_____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Ext. _____

Responsible Party Information (information used for patient balance statements)

Responsible Party □Another Patient □Guarantor □Self □Check here if information is same as Patient
Responsible Party Name (Last) _____ (First) _____ (MI) _____
Date of Birth MM____/DD____/YYYY_____ Social Security Number _____-_____-_____
Address _____ City_____ State_____ Zip_____

Primary Insurance Information
Insurance Company _____ Phone Number_____
Name of insured_____ Patient Relationship to Insured_____
Subscriber ID (Policy Number) _____ Group Number (ID) _____
Secondary Insurance Information
Insurance Company _____ Phone Number_____
Name of insured_____ Patient Relationship to Insured_____
Subscriber ID (Policy Number) _____ Group Number (ID) _____

I understand and agree that regardless of my insurance status that I am ultimately responsible for payment for any Professional Services administered by the Physicians, Nurses and Technical Staff of New Era Family Practice. I have read and answered the above questions to the best of my ability. I certify this information to be true and correct to the best of my knowledge. I agree to notify New Era Family practice of any changes that may occur to alter this information.

Patient Signature:_____ Date:_____

DR PARAG PATEL

126 S Coronado Dr. Suite B
Sierra Vista, AZ 85635
Phone: 520-439-0115
Fax: 520-458-3016

New Era Family Practice

*** CONFIDENTIAL PATIENT INFORMATION ***

Assignment of MEDICARE, MEDICARE HMOS AND MEDICAID Insurance Benefits

I authorize New Era Family Practice; holder of medical and personal information about me, to release to the Social Security Administration, Center for Medicare and Medicaid Services (CMS) or its' intermediaries and /or carriers, any information needed for submission of my Medicare/Medicaid claims. I authorize the use of a copy of this form, in place of the original. I request payment of my insurance benefits to be paid to the party who accepts assignment. I understand it is mandatory to notify New Era Family Practice of any other party that may be responsible for paying for my treatment.

Regulations pertaining to Medicare assignment of benefits also apply.

I understand that I am responsible for Co-Payments due as specified by my Medicare/Medicaid Plan.

Patient's Signature VALID FOR ONE YEAR FROM SIGNED DATE DATE

Assignment of CO-INSURANCE PLANS Benefits

I authorize New Era Family Practice to bill my insurance carrier for charges incurred during my course of treatment. I authorize payment to be made directly to New Era Family Practice.

I authorize the use of a copy of this form in place of the original. I also authorize New Era Family Practice to inquire about my claims, and receive any information about any and all of my insurance claims, assigned or unassigned. I understand that I am responsible for any deductibles and/or co-pays due from me as specified by my insurance policy.

Patient's Signature VALID FOR ONE YEAR FROM SIGNED DATE DATE

Assignment of ALL OTHER INSURANCE PLANS Benefits

I hereby instruct and direct _____ Insurance Company, to pay my insurance benefits directly to:

New Era Family Practice
PO Box 2186
Sierra Vista, AZ 85635-2186

If my current policy prohibits direct payment to my healthcare provider, I hereby instruct and direct my Insurance Company to pay me and mail checks to:

PO Box 21286
Sierra Vista, AZ 85635-2186

THIS IS A DIRECT ASSIGNMENT OF THE RIGHTS AND BENEFITS OF MY POLICY for the professional or medical expenses allowed and otherwise payable to me as payment toward the total charges of Professional services rendered. Said payments will not exceed my indebtedness to the above-mentioned assignee, and I agree to pay in a timely manner and balance due over and above the insurance payments.

I authorize the use of a copy of this form in place of the original. I also authorize the release of any information pertinent to my billing to insurance companies, adjusters, or attorneys involved in my welfare. I authorize New Era Family Practice to initiate a complaint to the Insurance Company for any reason on my behalf.

Patient's Signature DATE

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Permission to Relay Information

As required by the Health Insurance Portability and Accountability Act of 1996, you have the right to request that communications concerning your personal health information be made through confidential channels. If you request to receive confidential communications of PHI by alternative means, you must give us an alternative address or other method of contacting you. ***Some method of contact must be provided.***

We will not ask why you are making your request, and will make efforts to accommodate all reasonable requests.

This request supersedes any prior request for communication of information I may have made.

Extended Authorization

Please list any persons you would like to have access to your billing, appointment or health information (with the exclusion of information that is protected under State and Federal law), such as your spouse, caretaker or other family member:

Name	Relationship

Restrictions on Communication Methods

Our methods of communicating with you may be through mail, secure email, and telephone, including leaving messages on your answering machine/voice mail. Please indicate below anyways in which you do not want to receive communications:

- ☐ No restrictions
- ☐ No calls to phone number(s): _____
- ☐ No messages or voice mails left on phone number(s): _____
- ☐ No mail to the following address(es): _____
- ☐ Other (please specify): _____

Signature of Patient /Responsible Party	Date
Name of Patient /Responsible Party (please print)	Relationship to Patient

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I am able to obtain a copy of new Era Family Practice Notice of Privacy Practices.

Signature of Patient / Personal representative

Date

If signed by personal representative, relationship to patient

CANCELLATION POLICY

EFFECTIVE JANUARY 1, 2010 A FEE OF $25.00 WILL BE CHARGED FOR ALL "**NO SHOW APPOINTMENTS**". PLEASE CALL 24 HOURS IN ADVANCE TO CANCEL OR RE-SCHEDULE YOUR APPOINTMENT.FREQUENT "NO SHOWS" MAY RESULT IN US ASKING YOU TO FIND ANOTHER PHYSICIAN.

Signature

Date

Office Use Only:

Our office has made a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual to the named below.

Patient Name: _____

Refused to sign ☐ Physically unable to sign ☐

(Other)_____

_____

Front Office Employee Signature _____ Date _____

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New Era Family Practice

Visit our patient portal

Appointment Line: 520-439-0115 Fax: 520-458-3016

DISCLAIMER

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Some of the information contained on this site relates to medical topics and issues; however, no information on the site should be construed as medical advice. All questions regarding your health or possible health problems should be directed to your physician. This site included links to other Web sites, however, Keyamed, Inc., A P C, dba New Era Family Practice does not endorse the linked sites. Keyamed, Inc., A P C, dba New Era Family Practice does not take any responsibility for the content or information contained on the linked sites.

Print patient name

Patient Signature

If you want to register for patient portal, include email under name

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New Era Family Practice

Pharmacy Information

Name: _____

Preferred Pharmacy	Secondary Pharmacy
Name	Name
Address	Address
Phone	Phone
Fax	Fax

Advanced Directives

☐ None ☐ Do Not Resuscitate ☐ Durable Power of Attorney ☐ Living Will ☐ HC Proxy
Date Reviewed:

Medications

☐ I do not take medications.

List all medications you take, prescription and nonprescription, and their dosage.

Medication Name	Dosage
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

Medication and Food Allergies

☐ No Known Allergies

List all known allergies (DRUGS, FOOD, ANIMALS, ETC):

1.
2.
3.
4.
5.
6.
7.

Surgeries

Type	Year
1.	
2.	

Medical History

Please check if you have ever experienced any of the following conditions, and year of onset.

Condition	Year	Condition	Year
☐ None		☐ Gallbladder disease	
☐ Allergies		☐ GERD (Reflux)	
☐ Anemia		☐ Hepatitis C	
☐ Angina		☐ Hyperlipidemia	
☐ Anxiety		☐ Hypertension	

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Medical History (continued)

Condition	Year	Condition	Year
☐ Arthritis		☐ Irritable bowel disease	
☐ Asthma		☐ Liver disease	
☐ Atrial fibrillation		☐ Migraine Headache	
☐ Benign prostatic hypertrophy		☐ Myocardial infarction	
☐ Blood clots		☐ Osteoarthritis	
☐ Cancer Type:		☐ Osteoporosis	
☐ Cerebrovascular accident		☐ Peptic ulcer disease	
☐ Coronary artery disease		☐ Renal disease	
☐ COPD (Emphysema)		☐ Seizure disorder	
☐ Crohn's disease		☐ Thyroid disease	
☐ Depression		☐ Other	
☐ Diabetes		☐ Other	

Family History

Please check if any family member has had any of the following conditions. ☐ Adopted

Diagnosis	Mother	Father	Sister	Brother	Other	Other	Other
Alcoholism							
Alzheimer's Disease							
Asthma							
Blood disease							
CAD (heart attack)							
Cancer Type:							
CVA (stroke)							
Diabetes							
Hyperlipidemia (high cholesterol)							
Hypertension (high blood pressure)							
Other:							
Other:							

Social History

Marital Status:	☐ Married ☐ Engaged ☐ Single ☐ Divorced ☐ Widowed
Employment Status:	☐ Full Time ☐ Part Time ☐ Retired ☐ Student Other _____
Tobacco Use:	☐ Yes ☐ No ☐ Former / Year Quit: _____ Type: ☐ Chewing ☐ Pipe ☐ Cigar ☐ Cigarette ☐ Smokeless Frequency: ☐ Daily ☐ Some days ☐ Not Sure
Alcohol Use:	☐ Never ☐ Yes ☐ No ☐ Former / Year Quit: _____ Type: ☐ Beer ☐ Liquor ☐ Wine ☐ Other _____ Frequency: ☐ Daily ☐ Some days ☐ Not Sure
Exercise/Activity	Level: ☐ Moderate ☐ Sedentary ☐ Vigorous Frequency: ☐ Daily ☐ Some days ☐ Not sure
Caffeine Use:	Never Yes No Former/ Year Quit: _____ Type: ☐ Chocolate ☐ Coffee ☐ Soda ☐ Tablets ☐ Tea Other: _____ Frequency: ☐ Daily ☐ Some days ☐ Not sure